UNIVERSAL REFERRAL FORM

 

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| **Youth Name** *(First, Middle, Last)* |  Identifies as **Pronouns:**  | ☐ M ☐ F  | DOB: |       **Age:**       |
| Type of Referral: | ☐ 35 Day Evaluation ☐ Shelter ☐ SEY Transition Living ☐ Crisis Stabilization☐ Residential Treatment ☐ Transitional Living ☐ Group Home |
| Youth S.S. Number:        |  | Race:       If applicable, Tribe:       |  |
| Youth’s Current Placement:       |
|  |
| Information |
|  |
| **Referring Agency: Worker’s Name** |  **Phone/ Email: County:** |
| Referral Agency Contact Information: |
| Direct Line:       Mailing Address:       |
| Cell:       Email Address:       |
| Other Professionals Currently Working with this Child: |
| Agency: Workers Name: Phone/ Email: Involved in Treatment: ☐ Yes ☐ No  |
|  |
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|  |
| Type of Placement: ☐ Court Order ☐ Social Service ☐ Voluntary ☐ Other:      *A copy of the hold and placement agreement will be required upon placement.*  |
| FAMILY INFO: | Adoptive/ Bio/Step | Mailing Address | Date of Birth | Parent Email Address  |
| Parent |       |       |       |  |  |
| Full Name:       Home Phone:       Cell Phone:        |
| Parent |       |       |       |  |  |
| Full Name:       Home Phone:       Cell Phone:       **Identify Physical and Legal Custody of the Child:** **NAME AND CONTACT INFORMATION**: AGE: |
| Siblings                       | ☐ M☐ F |  |       |       |  | Limits to contact       |
| ☐ M☐ F |  |       |       |  | Limits to contact       |
| ☐ M☐ F |  |       |       | Limits to contact       |
| ☐ M☐ F |  |       |       | Limits to contact       |
| **Are there any restrictions on either parent’s involvement?** If so, please indicate here:       |
| Please describe why you are making this referral, describe the treatment goals of placement, and what is the permanency/ post placement plan:  |

| History of Services Delivered: |
| --- |
| Outpatient Services (therapy, day treatment, partial hospitalization): |
| Name of Agency:  | Dates of Service: | Result: |
|       |       |       |
|       |       |       |
|       |       |       |
| Residential/Inpatient Services (including hospitalizations): |
| Name of Agency:  | Dates of Service: | Result: |
|       |       |       |
|       |       |       |
|       |       |       |
| **What is the child’s IQ?**  |
| Delinquency History: ☐ Yes ☐ No Youth’s Previous Offenses |
| Year | Offense (also explain the original charges if you are on probation) | Outcome |
|       |       |       |
|       |       |       |
| List your prescribed medications and over-the-counter drugs, such as vitamins and inhalers |
| Name of Current Pharmacy:       | Pharmacy Phone Number:        |
| Name of Medication: | Strength / Mg | Frequency Taken | Name of Current Prescriber & Clinic Associated With: |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| Allergies  |
| To | Reaction Had |
|       |       |
|       |       |
| History |
|  |
| All questions contained in this questionnaire will be kept strictly confidential. |
| Abuse History | ☐ Neglect Perpetrator(s):       |
| ☐ Physical Perpetrator(s):       |
| ☐ Emotional/Psychological Perpetrator(s):       |
| ☐ Sexual Perpetrator(s):       |
| Risk of Harm to Self | Is there a history of cutting or self injurious behavior (SIB)? | ☐ | Yes | ☐ | No |
| Is there a history of suicidal ideation? | ☐ | Yes | ☐ | No |
| # of suicide attempts?       |
| FASD | ☐ None | ☐ Suspected | ☐ Has Diagnosis |
| If diagnosed, name of Diagnostic Clinic/Professional?       |
| Risk of Harm to Others | History of Sexual Behaviors or Talk? | ☐ | Yes | ☐ | No |
| If yes, please describe?       |
| Has the youth successfully completed treatment to address the behaviors/talk?       |
| History of cruelty to animals? | ☐ | Yes | ☐ | No |
| Verbally abusive to others? | ☐ | Yes | ☐ | No |
| Physically abusive to others? | ☐ | Yes | ☐ | No |
| Gang involvement? | ☐ | Yes | ☐ | No |
| Difficulties with peer relationships? | ☐ | Yes | ☐ | No |
| Run Risk | History of running away? | ☐ | Yes | ☐ | No |
| ☐ Recent – time gone:       | ☐ months ago:       | ☐ years ago:       |
| Places youth goes:       |
| Homelessness | Does the youth have a history of being homeless? | ☐ | Yes | ☐ | No |
| Drugs / Alcohol | Does youth currently use recreational or street drugs? | ☐ | Yes | ☐ | No |
| Does youth currently use alcohol? | ☐ | Yes | ☐ | No |
| Mental Health | Does the youth have an eating disorder or suspected eating disorder? | ☐ | Yes | ☐ | No |
| Does the youth have grief or loss suffering? | ☐ | Yes | ☐ | No |
| If so, describe loss and month/season it occurred:       |
| Does the youth have difficulty with parental relationships? | ☐ | Yes | ☐ | No |
| Additional Questions | Lying or Cheating concerns? | ☐ | Yes | ☐ | No |
| Enuresis or Encopresis history/current concern?  | ☐ | Yes | ☐ | No |
| Does the youth have vision or hearing loss? | ☐ | Yes | ☐ | No |
| Does the youth have history of gang involvement? | ☐ | Yes | ☐ | No |
| Is there a history or concern of truancy or lack of academic motivation? | ☐ | Yes | ☐ | No |
| Does the youth have identity issues? | ☐ | Yes | ☐ | No |
|  | Does the youth have a history of Sexual Exploitation? | ☐ | Yes | ☐ | No |
|  |  |
|  | Is there a current diagnostic/functional assessment? ☐ Yes ☐ No Date:       Provider/ Agency:       |
|  | Current School Attending: Is youth on an IEP? ☐ Yes ☐ No  Grade:       |
|  | Strengths of youth/family:       |
|  | Physical restrictions for the youth:   ☐ Yes ☐ No     The developmental, educational, cultural, and mental health needs can be met by the program: ☐ Yes ☐ No |
|  | Primary Physician– Please provide Name of Clinic, Physician, Dentist and Phone#:      Primary Dentist-  |
|  |  |
|  | **INSURANCE INFORMATION - A Copy of Insurance card is required** |
|  | Name of Primary Insurance:        |
|  | **Is this a PMAP?** | ☐ | Yes | ☐ | No |
|  | **Has the placement been approved by the PMAP?** | ☐ | Yes | ☐ | No |
|  | **Have you requested a faxed confirmation?** | ☐ | Yes | ☐ | No |
|  | Address of Insurance:       Telephone number:       |
|  | Name of Insured:       Relationship to Youth:       Insured DOB:       |
|  | Insured ID Number:       Group Number:       Name of Insured Employer:       |
|  | **Is there a Secondary Insurance?** | ☐ | Yes | ☐ | No |
|  | Name of Secondary Insurance:       |
|  | Address of Insurance:       Telephone number:       |
|  | Name of Insured:       Relationship to Youth:       Insured DOB:       |
|  | Insured ID Number:       Group Number:       Name of Insured Employer:       |

|  | Requested additional service |
| --- | --- |
|  | Additional services requested. Specific information can be added in the space provided. |
| ☐ | Psychological Evaluation:       |
| ☐ | Individual Therapy:       |
| ☐ | Family Therapy:       |
| ☐ | Substance Use Assessment:       |
| ☐ | Religious / Cultural Needs:       |
| ☐ | Medication Management:       |
| ☐ | Diagnostic Assessment:       |
| ☐ | Other:       |

Please return his form with the following documentation:

* Most recent Diagnostic Assessment
* Psychological and Neuropsychological Evaluation (Most recent if more than one)
* Psychiatric Evaluation (Most recent if more than one)
* Discharge Summaries from previous placements
* Progress Reports from current placements
* Individual Education Plan
* Most recent school evaluation
* CASII (not required)