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: | | | | | | | | | | | | | | | |
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| Information | | | | | | | | | | | | | | | |
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| **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: | | | | | | | | |
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| Residential/Inpatient Services (including hospitalizations): | | | | | | | | | | | | | | | | | | |
| Name of Agency: | | | Dates of Service: | | | | | | | Result: | | | | | | | | |
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| **What is the child’s IQ?** | | | | | | | | | | | | | | | | | | |
| Delinquency History: ☐ Yes ☐ NoYouth’s Previous Offenses | | | | | | | | | | | | | | | | | | |
| Year | | | Offense (also explain the original charges if you are on probation) | | | | | | | Outcome | | | | | | | | |
|  | | |  | | | | | | |  | | | | | | | | |
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| 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: | | | | | | | | | | |
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| Allergies | | | | | | | | | | | | | | | | | | |
| To | | | | | Reaction Had | | | | | | | | | | | | | |
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| History | | | | | | | | | | | | | | | | | | |
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| 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)