60-Day Review - Referral Form

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| Child Information | | | |
| NAME: | | medicaid number: | Social Security Number: |
| Date of Birth: | | Gender:  Male  Female | |
| County of Origin: | | Circuit: | Area: |
| Current Medications: | | | |
| Single Point of Access (SPOA) Contact Information | | | |
| NAME: | | Phone number: | email: |
| Current Mental Health Issues, Treatment Progress | | | |
|  | | | |
| **DESIRED TREATMENT OUTCOME** | | | |
|  | | | |
| **SUMMARY OF PERMANENCY PLAN GOALS, INCLUDING PLANNED DISCHARGE PLACEMENT** | | | |
|  | | | |
| Current dsm-5 diagnosis | | | |
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|  |  | | |
|  |  | | |
| Prescribing Physician | | | |
| NAME: | | Phone number: | |

| Child’s Current Living Arrangement | | | | | |
| --- | --- | --- | --- | --- | --- |
| Name of current location/Placement: | | | | | |
| Admission Date to Residential Treatment Facility: | | placement type:  In-Patient  STGH | | | |
| Daytime phone number: | evening phone number: | | | | |
| Address: | City: | | | State: | Zip: |
| Community Based Care Caseworker | | | | | |
| Name: | Phone Number: | | | Email Address: | |
| Address: | City: | | | State: | Zip: |
| Guardian ad litem | | | | | |
| Name: | | | Email Address: | | |
| Phone Number: | | Fax Number: | | | |
| Attorney Ad Litem | | | | | |
| Name: | | | Email Address: | | |
| Phone Number: | | Fax Number: | | | |

| Checklist of required documents (mental health must be marked). This section must be filled out to process the referral. |
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| Comprehensive Behavioral Health Assessment |
| Mental health treatment history, current |
| Court Information:  Shelter Petition,  Shelter Order,  Judicial review,  Case Plan |
| Evaluations:  Psychological,  Psychiatric, Psychosocial,  Psychosexual Evaluations |
| Treatment Provider documentation:  treatment plan,  counseling/Medication Management/ABA |
| Delinquency Information (DJJ, JDC, Probation, etc.) |
| Multidisciplinary team (MDT) meeting Note (for a child not currently placed in residential treatment) |

We believe that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a child in the custody of the Department of Children and Families/CBC, is emotionally disturbed and may need residential treatment, pursuant to Section 39.407, Florida Statute.

I certify the referral form and package are complete and that all information will be provided to the Qualified Evaluator upon assignment.

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| Signature of SPOA |  | Date |