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 |
|  |  |
|  |  |
|  |  |
| 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 |