90-Day Review for Child placed Out-of-State for  
Residential Treatment – Referral Form

Revised: October 16, 2019

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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: | | | |
| Point of Contact (POC) Contact Information | | | |
| NAME: | | Phone number: | EMAIL: |
| Current Mental Health Issues, Treatment Progress | | | |
|  | | | |
| **DESIRED TREATMENT OUTCOME** | | | |
|  | | | |
| CURRENT Treatment DSM-5 Diagnosis (includE ICD-10 CM codes): | | | |
|  |  | | |
|  |  | | |
|  |  | | |
|  |  | | |
| Prescribing Physician at Facility | | | |
| NAME: | | Phone number: | |

| Child’s Current Out of State Placement Location | | | |
| --- | --- | --- | --- |
| Name of Treatment Facility: | | | |
| placement type:  In-Patient  STGH  Other: | | | |
| Contact representative at facility: | contact representative phone number: | | |
| Contact representative e-mail address: | \*video conferencing invite will be sent to the e-mail provided to the left | | |
| 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 facility documents that must be provided to the qualified evaluator |
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| current treatment plan |
| current medication logs |
| Mental health treatment history |
| Court Information:  placement Order,  other |
| Individual Education Plan |
| Evaluations:  Psychological,  Psychiatric, Psychosocial,  Psychosexual |
| Provider Clinical Notes,  Multidisciplinary team service plan,  including implementation results |
| DJJ Information (DJJ, JDC, Probation, etc.) |
| Other (please specify): |

We believe that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a child in the custody of the Department of Children and Families/CBC, is emotionally disturbed and may need residential treatment, in accordance with the Child and Family Operating Procedure No. 170-11 (CFOP 170-11).

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 |