Reconsideration – 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: | |
| Evaluator: | Date of Last Suitability: | | Prior Recommendation:  In-Patient  STGH  Residential Not Recommended | | |
| Single Point of Access (SPOA) Contact Information | | | | | |
| NAME: | | Phone number: | | | EMAIL: |

| Child’s Current Living Arrangement | | | |
| --- | --- | --- | --- |
| Name of current location/Caregiver: | | | |
| placement type:  In-Patient  STGH  Shelter  Detention Center  CSU  Foster Parent  Relative  Other: | | | |
| Daytime phone number | evening phone number | | |
| Address: | City: | State: | Zip: |

| Community Based Care Caseworker | | | | |
| --- | --- | --- | --- | --- |
| Name: | Phone Number: | E-mail Address: | | |
| Address: | City: | | State: | Zip: |

| Guardian ad litem | | |
| --- | --- | --- |
| Name: | | E-mail Address: |
| Phone Number: | Fax Number: | |

| Attorney ad litem | | |
| --- | --- | --- |
| Name: | | E-mail Address: |
| Phone Number: | Fax Number: | |

| Updated Clinical Information: explanation of child’s decompensation since the time of the last assessment (i.e., Baker Acts, self-injurious behaviors, etc.) |
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| **DESIRED TREATMENT OUTCOME** |
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| **SUMMARY OF PERMANENCY PLAN GOALS, INCLUDING PLANNED DISCHARGE PLACEMENT** |
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| --- | --- |
| Current dsm-5 diagnosis | |
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| 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, INCLUDING updated Records since the time of the last assessment |
| 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.) |

| Additional Comments or Information |
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I certify the referral form and package are complete and that all information will be sent to the Qualified Evaluator upon assignment.

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| Signature of SPOA |  | Date |