Out of State Review - Referral Form

Revised: July 15, 2020

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| Referral Type: | Select Type |

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| Child Information |
| NAME: | **DATE OF BIRTH:** | **GENDER:**[ ]  Male [ ]  Female |
| **COUNTY OF ORIGIN:** | circuit: | area: |
| Does the child require an interpreter? [ ]  Yes [ ]  No**If yes, please explain how interpreter services will be provided to the child**:  |
|

| Single Point of Access (SPOA) Contact Information |
| --- |
| NAME:  | Phone number: | fax: | **E-MAIL:**  |

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| DSM-5 Diagnosis / ICD-10 Codes |
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| Current Medications |
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| Child’s Current Out of State Placement Location |
| Name of Treatment facility:  |
| placement type:[ ]  In-Patient [ ]  STGH [ ]  Other: **ADMISSION DATE (60-Day Review):**  |
| ADDRESS: | cITY: | STATE: | ZIP: |
| **CONTACT REPRESENTATIVE/TITLE AT FACILITY:** | **CONTACT REPRESENTATIVE PHONE NUMBER:** |
| **CONTACT REPRESENTATIVE E-MAIL ADDRESS: (Video conferencing invite will be sent to this e-mail address)** |

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

| Guardian Ad Litem |
| --- |
| Name:  | Phone Number: | Email Address: |

| Attorney Ad Litem |
| --- |
| Name:  | Phone Number: | Email Address: |

| Current mental health issues, treatement progress  |
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| Desired Outcomes of Residential Treatment  |
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| Summary of permanency plan goals for the youth (including planned discharge placement)  |
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| required facility documents that must be provided to the Qualified evaluator  |
| [ ]  multidisciplinary team (MDT) meeting note  |
| [ ]  Mental health treatment history[ ]  Psychological, [ ]  Psychiatric, [ ]  Psychosocial, [ ]  Psychosexual Evaluations[ ]  therapy, [ ]  treatment plan, [ ]  Medication Management, [ ]  ABA |
| [ ]  Court Information: [ ]  placement order, [ ]  other |
| [ ]  Delinquency Information (DJJ, JDC, Probation, etc.) |
| [ ]  Individual Education Plan |
| [ ]  Other (please specify): |
|  |
| **additional contacts or information** |
|  |

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.

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| Signature of Community based care case worker |  | Date |

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

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| Signature of SPOA |  | Date |