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 | | |
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| 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): |
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| **additional contacts or information** |
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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 |