Suitability Assessment & Review - Referral Form

Revised: October 12, 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: |
| date of last MDT Meeting: | | recommendation outcome from MDT: | | Does the child require an interpreter?  Yes  No  If yes, please explain how interpreter services will be provided to the child: | |
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| | 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 Living Arrangement | | | | | |
| Name of current location/placement: | | | | | |
| placement type:  In-Patient  STGH  Shelter  Detention Center  CSU  Foster Home  Relative  Other: | | | | | |
| **DAYTIME PHONE NUMBER:** | | | **ADDRESS:** | | |
| **CITY:** | | | **STATE:** | | **ZIP:** |

| 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: |
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| initial assessments only:  Why child is being referred for residential treatment (Detailed mental health information required) | |
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| **60-DAY REVIEW ONLY**  **Current treatment plan goals and objectives, child’s progress towards treatment, any issues noted since admission into residential program** | |
| **Admission Date to residential treatment facility:** |  |
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| 90-Day review only:  Current mental health issues, clinical update since prior assessment, treatment progress |
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| reconsideration only:  Description of clinical decompensation since prior assessment and/or outline of supporting documentation not provided at the time of the prior assessment |
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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 documents (MENTAL HEALTH treatment history MUST BE checked) |
| Comprehensive Behavioral Health Assessment |
| multidisciplinary team (MDT) meeting note (NOT required if referral is court ordered) |
| Mental health treatment history – at least the last 12 months  Initial assessments - at least the last 12 months  60 & 90-Day Reviews – Current  Psychological,  Psychiatric,  Psychosocial,  Psychosexual Evaluations  therapy,  treatment plan,  Medication Management,  ABA |
| Court Information:  Shelter Petition,  Shelter Order,  Judicial review,  Case Plan |
| 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 |