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 [ ]  NoIf yes, please explain how interpreter services will be provided to the child:  |
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| Single Point of Access (SPOA) Contact Information |
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| 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 |