Suitability Assessment & Review - Referral Form

Revised: June 2024

Referral Type:	Select Type

Child Information		
Name:	Date of Birth:	Gender: Select
Race/Ethnicity: Select	Date of last MDT Meeting:	MDT Level of Care Recommendation: Select LOC
County of Origin:	Circuit:	If Other explain:
Does the child require an interpreter? Select If yes, please explain how interpreter services will be provided to the child:		

Point of Contact (POC) Contact Information	
Name:	Phone Number:
CBC Name:	Email:

DSM V Diagnosis(es) / ICD 10 Codes (from most recent evaluation)			
Evaluation Type: Psychiatric ☐	Psychological ☐	Neuropsychological ☐	Other ☐ Explain:
Who conducted the evaluation (name)?			Date of evaluation:
Diagnosis(es):			

Current medications

Prior mental/behavioral health residential treatment	Yes ☐ (If yes, please explain below and include outcome)	No ☐

Child's current living arrangement	
Name of current location/placement:	
Placement Type: Select	☐ Other:

Daytime Phone Number:	Address:	
City:	State:	Zip:

REQUIRED INFORMATION			
Treating Clinical Professional ☐ **N/A**			
Name:	Phone Number:	Email Address:	
Community Based Care Caseworker			
Name:	Phone Number:	Email Address:	
Address:	City:	State:	Zip:
Guardian Ad Litem ☐ **N/A**			
Name:	Phone Number:	Email Address:	
Attorney Ad Litem ☐ **N/A**			
Name:	Phone Number:	Email Address:	

Assessments/Reviews will be conducted via TELEHEALTH unless otherwise specified	
Primary Contact Representative **(Will be the person responsible for being present with the child at the time of the interview)**	
Primary Contact Representative Name(s)/Title(s):	
Primary Contact Representative's Phone Number(s):	
**Video conferencing invite will be sent to this email address* Primary Contact Representative's Email Address(s):	
Secondary Contact Representative (if needed)	
Secondary Contact Representative Name(s)/Title(s):	
Secondary Contact Representative's Phone Number(s):	
Secondary Contact Representative's Email Address(s):	
Third Contact Representative (if needed)	
Third Contact Representative Name(s)/Title(s):	
Third Contact Representative's Phone Number(s):	
Third Contact Representative's Email Address(s):	
Face-to-Face (special circumstance) Select	Explain special circumstance:

INITIAL ASSESSMENT ONLY Why child is being referred for residential treatment (Detailed mental, emotional, and behavioral health information required)

60-DAY REVIEW ONLY (including OOS) 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:	

90-DAY REVIEW ONLY (including OOS) Current mental, emotional, and/or behavioral health issues. Child's progress towards achieving goals and objectives of treatment plan

RECONSIDERATION ONLY (including OOS) Description of child's mental, emotional and/or behavioral decompensation since prior assessment and/or outline of supporting documentation not provided at the time of the prior assessment

Desired outcomes of residential treatment

Recommendation of the child's treating clinical professional (member of permanency team)

Explain why the child's needs cannot be met by his/her family or in a foster family

Planned Permanency	
Caregiver Name/Relation to Child:	☐ Unknown:
Summary of permanency plan goals for the youth (including planned discharge placement)	

Required documents
☐ Comprehensive Behavioral Health Assessment *(Initials ONLY)*

☐ Multidisciplinary Team (MDT) meeting note *(NOT required if referral is court ordered)*
☐ Comprehensive Placement Assessment
Mental Health Treatment History – At least last 6 months ☐ Psychological, ☐ Psychiatric, ☐ Psychosocial, ☐ Psychosexual evaluations ☐ Therapy, ☐ Treatment plan, ☐ Medication management, ☐ ABA
☐ Delinquency information (DJJ, JDC, Probation, etc.)
☐ Other (please specify):

Additional 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.

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.

SIGNATURE OF POC **DATE**

Additional Collateral Contacts

Family Member(s)		
Name/Relation to Child:	Phone Number:	Email Address:
Name/Relation to Child:	Phone Number:	Email Address:
Name/Relation to Child:	Phone Number:	Email Address:
Other/Relation to child:		
Name/Relation to Child:	Phone Number:	Email Address:
Name/Relation to Child:	Phone Number:	Email Address:

Include CBC Logo here

AUTHORIZATION FOR QUALIFIED EVALUATOR

Child's Name:	Date of Birth:
Authorization Beginning Date:	(Authorization is valid for 90 days)

Pursuant to: Select

_____ *a Qualified Evaluator contracted by Magellan of Florida, is authorized to have access to the child via secure video teleconference or face-to-face for in state and telephonic or secure video teleconference for out of state, to members of the child's treatment team and to the child's clinical records for the purpose of producing a report to the Department of Children & Families. Qualified Evaluators must satisfy F.S. 39.407(6)(b)1. and 2. The Department will submit to the juvenile court the Qualified Evaluator's report, which will summarize the child's progress toward achieving the goals and objectives of the individualized treatment plan that is on file with the court.*

If there are any questions about this authorization, please contact me at ( ) ____-_____

Thank you for your cooperation.

Sincerely,

_____

Signature

(Type name)
Point of Contact
(Type name of CBC)