

Suitability Assessment & Review - Referral Form

Revised: August 16, 2023

Referral Type:	Select Type
-----------------------	--------------------

Child Information		
Name:	Date of Birth:	Gender: Select
Race/Ethnicity: Select	Date of last MDT Meeting:	Recommendation from MDT:
County of Origin:	Circuit:	Area:
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 <input type="checkbox"/>	Psychological <input type="checkbox"/>	Neuropsychological <input type="checkbox"/>	Other <input type="checkbox"/> Explain:
Who conducted the evaluation (name)?		Date of evaluation:	

Current medications

Child's current living arrangement		
Name of current location/placement:		
Placement Type: Select	<input type="checkbox"/> 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) <input type="checkbox"/> 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*)

Mental Health Treatment History – At least last 6 months

- Psychological, Psychiatric, Psychosocial, Psychosexual evaluations
- Therapy, Treatment plan, Medication management, ABA

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)