Suitability Assessment & Review - Referral Form

Revised: September 27, 2021

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:
Fax:	Email:

DSM V Diagnosis(es) / ICD 10 Codes

Current medications

Child's current living arrangement		
Name of current location/placement:		
Placement Type: Select		☐ 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			
Name:	Phone Number:	Email Address:	

Assessments/Reviews will be conducted via TELEHEALTH unless otherwise specified	
Contact Representative Name(s)/Title(s):	Contact Representative's Phone Number(s):
Contact Representative's Email Address(s) (Video conferencing invite will be sent to this email address):	
Face-to-Face (special circumstance) Select	Explain special circumstance:

INITIAL ASSESSMENT ONLY Why child is being referred for residential treatment (Detailed mental 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 health issues, clinical update since prior assessment and treatment progress

RECONSIDERATION ONLY (including OOS) Description of clinical 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
☐ 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: