# BQRTP - Referral Form

Revised: March 2025

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

| Child Information | | |
|---|---|---|
| Name: | Date of Birth: | Gender: Select |
| Race/Ethnicity: Select | Date of last MDT Meeting: | MDT Recommendation: Select LOC |
| County of Origin: | Circuit: | Area: |
| **Does the child require an interpreter?** Select<br>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 * If applicable (from most recent evaluation) | | | |
|---|---|---|---|
| Evaluation Type: Psychiatric ☐ | Psychological ☐ | Neuropsychological ☐ | Other ☐ Explain: |
| Who conducted the evaluation? (name) | | | Date of evaluation: |
| Diagnosis(es): | | | |

| 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.** | |
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| **Primary Contact Representative**<br>**(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*<br>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: |

| **FULL ASSESSMENT ONLY**<br>Current treatment plan goals and objectives, child's progress towards treatment, any issues noted since admission into BQRTP. | |
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| **Admission date to BQRTP:** | |
| | |

| **90-DAY REVIEWS ONLY**<br>Current emotional and/or behavioral health issues or disturbances. Child's progress towards achieving goals and objectives of treatment plan. |
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| |
| **RECONSIDERATION ONLY**<br>Select all that apply:<br>☐ The QE was not provided with the clinical record/supporting documentation at the time the assessment/review was conducted.<br>☐ The child has experienced a decompensation in mental, emotional, or behavioral health functioning since prior assessment.<br>☐ The QE did not recommend a BQRTP, and the courts ordered the child to be placed in a BQRTP. |
| Must provide an explanation of all reasons selected: |

| **Desired outcomes of treatment** |
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| |

| **Current Recommendation of the child's treating clinical professional** |
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| |

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

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

| **Required documents** |
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| ☐ Comprehensive Placement Assessment - including supportive documentation |
| ☐ Multidisciplinary Team (MDT) meeting note *(NOT required if referral is court ordered)* |
| ☐ Comprehensive Behavioral Health Assessment |
| ☐ BQRTP treatment records (i.e., treatment plans, progress notes, etc.) |
| ☐ Delinquency information (DJJ, JDC, Probation, etc.) |

| |
|---|
| ☐ Other (please specify): |

| **Additional Information** |
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| |

We believe that _____, a child in the custody of the Department of Children and Families/CBC, has a serious emotional or behavioral disorder or disturbances and may need a BQRTP placement.

**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: Florida Rule 65C-28.021

_____, *a Qualified Evaluator contracted by Magellan of Florida, is authorized to have access to the child via secure video teleconference or face-to-face and 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)