Universal Child Welfare
&
Juvenile Justice

Referral Packet for Community Mental Health Services

March 1, 2012

Completion of all 6 pages of the referral packet will help support child/youth receiving mental health services in a timely manner and improve communication between agencies.

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Child/Youth's Full Name:_____Date of Birth:_____/_____/_____Age: _____

Social Security Number: _____ County of Court Jurisdiction_____

I _____hereby authorize the disclosure of written and/or verbal information checked below:

Name of Agency:_____ Address of Office:_____

City, State, Zip: _____Telephone Number:_____

_____ To Disclose To AND/OR _____ To Obtain From

Name of Agency:_____ Provider Name if Applicable:_____

Address:_____ City, State, Zip:_____

Telephone Number: _____

	Entry/ Admission Report		Case Consultations
	Admission Evaluation Plan		Discharge Summary/Report
	Case Plan/Treatment Plan		HIV Testing, HIV Status, AIDS, TB or Hepatitis
	Diagnosis/Prognosis		Medical/Physical History/Reports, Lab Results, X-Rays, Meds Prescribed
	Psychological Evaluation Report & Recommendations		Educational and/or Special Education Reports
	Psychiatric Evaluation Report		Verbal Communication
	Psychotherapy Progress Notes/Log Notes/Reports		Other
	Alcohol and/or Drug Treatment Information, KCPC, Evaluation, Treatment Plan, Discharge Summary		

All of the records authorized above may be released unless actual dates of treatment are specified here: _____

A. It is understood that this information will be used for the purpose of:

☐ Evaluation ☐ Treatment ☐ Follow-Up Care ☐ Other (specify) _____

*I understand I may revoke this authorization verbally or in writing at any time except for any information that has already been sent. Unless I revoke it earlier, this authorization expires: (check one)

☐ Specific date or event as indicated; not to exceed one year. _____
☐ If no expiration date is specified, this authorization automatically expires one year from date of signature.

I understand information used or disclosed to any entity other than a health plan or health care provider may no longer be protected under the federal privacy law.
I understand that Kansas State Medicaid Providers will not condition treatment on my signing this authorization.

B. Signature of either party is acceptable:

Signature of Patient_____ Date _____
(Age 18 or older for Mental Health TX Services and age 14 or older for Substance Abuse TX Services)

Signature of Parent or Legal Guardian _____ Date _____

Printed Name of Person Authorized to Sign _____

Relationship to Child/Youth_____

Address and Phone # _____

C. Signature of Witness _____ Date _____

* NOTICE TO RECIPIENT OF RECORDS: If these records are protected by 42 C.F.R. Part 2 protecting substance abuse treatment information, any further disclosure of this information is PROHIBITED. The individual who authorized this disclosure understands that the information may contain psychiatric information, mental health information, substance abuse treatment information, and HIV/AIDS (or other communicable disease) information.

Consent for Mental Health Treatment
for Child/Youth in Foster Care or Juvenile Justice System

By signing below you are authorizing the designated Community Mental Health Center (CMHC) to provide the minor child named below with mental health and/or substance abuse services, which may include individual counseling, group therapy, psychiatric evaluation, medication services (including prescribing medications), and/or other related services. These services will be provided by the CMHC in accordance with appropriate state and federal laws.

I, _____(Print Name of Guardian or Legally Authorized Agency Representative) do hereby consent for _____ (Print Name of Child/Youth) to receive mental health services as listed above) at _____(Print Name of the CMHC).

Name of Child/Youth: _____ **Date of Birth:** ____/____/_____

Child/Youth's Social Security Number: _____

Name of Parent/Relative, Guardian or Foster Parent in whose home this child/youth will be residing:

_____

Phone Number for Parent/Relative, Guardian or Foster Parent: _____

Street Address where child/youth will be residing while in treatment:_____

City, State, Zip code: _____

Name of Guardian or Legally Authorized Agency Representative responsible for child/youth:

_____

Phone Number for Guardian and/or Legally Authorized Agency Representative Office Number_____

Cell Phone Number:_____ Agency Name:_____

Signature of Guardian or Legally Authorized Agency Representative:_____**Date:**_____

Signature of Witness:

_____**Date:**_____

Signature of Child/Youth: _____**Date:**_____
(Age 13 or older for Mental Health Treatment and 14 or older for Substance Abuse Treatment)

Foster Care or Juvenile Justice Mental Health Referral

Child/Youth Name: _____ Date of Birth: _____/_____/_____

Address (where residing): _____ Phone: (H) _____

City, State, Zip: _____ Social Security #: _____

Name of Child Welfare or JJA Management Provider Designee legally authorized to consent for treatment: _____

_____

Role: _____

Address, City and State: _____

Child Welfare or JJA Agency: _____

Work Phone: _____ Cell Phone: _____

SEX	RACE	ETHNICITY	ELIGIBILITY FOR SSI OR SSDI
☐Male	☐ American Indian or Alaska Native	☐ Hispanic or Latino	☐ Not Applicable
☐Female	☐ Asian	☐ Not Hispanic or Latino	☐ Eligible and Receiving Payment
	☐ Black or African American		☐ Eligible but not Receiving Payment
	☐ Native Hawaiian or Other Pacific Islander		☐ Potentially Eligible
	☐ White		☐ Determined to be Ineligible by Review and Decision
	☐ Other		☐ Determination Decision on Appeal

EDUCATION

Name of School: _____ Present Grade: _____

Special Education Services: ☐Yes ☐No

Most grades are currently: ☐A ☐B ☐C ☐D ☐F

Recent History of Present Situation

Please describe the problems you are concerned about regarding this child/youth (please attach additional paper if necessary):

_____

_____

_____

_____

_____

How long have you been concerned about this child/youth? _____

Family history of mental illness? ☐Yes ☐No ☐ Unknown (e.g., depression, schizophrenia, etc.)

If yes, explain: _____

Family history of substance abuse? ☐Yes ☐No ☐ Unknown

If yes, explain: _____

History of family suicidal, homicidal, or self-injurious behavior? ☐Yes ☐No ☐Unknown

If yes explain: _____

History of child/youth suicidal, homicidal, or self-injurious behaviors? ☐Yes ☐No ☐Unknown

If yes explain: _____

Has this child/youth ever been sexually abused? ☐Yes ☐No ☐Unknown

If yes explain: _____

Has this child/youth ever been physically abused? ☐Yes ☐No ☐Unknown

If yes explain: _____

Has this child/youth ever been neglected? ☐Yes ☐No ☐Unknown

If yes explain: _____

Family Information

Please list all members of the family-of-origin and give related information:

NAME	RELATIONSHIP TO CHILD/YOUTH (Father, Stepfather, etc.)	AGE	RESIDENCE

Who is child/youth closest to in his/her family? _____

What do you consider to be this child/youth's strengths? _____

Please describe mother's health during pregnancy with this child/youth: _____

Any pregnancy problems? ☐Yes ☐No ☐Unknown
If yes explain: _____

Were there any health problems during infancy or early childhood? ☐Yes ☐No ☐Unknown
If yes explain: _____

Are there any developmental issues? (walking, talking, potty training, etc.) ☐Yes ☐No ☐Unknown
If yes explain: _____

Does the child/youth have any MR/DD issues? ☐Yes ☐No ☐Unknown
If yes explain: _____

Medical Information

Is this child/youth currently experiencing any illness or physical complaints? ☐Yes ☐No
If yes explain: _____
Please list all prescription medications this child/youth is **currently** taking and dosage:

_____

_____

Name of Physician who prescribed these: _____
Please list all prescription medications this child/youth has taken in the **past six months:**

_____

_____

Please list all current over-the-counter medications or herbal preparations this child/youth is taking (kind and quantity):

_____

_____

What medications has this child/youth **previously** taken for psychiatric conditions?

_____

Please list all drug allergies and adverse reactions this child/youth has had to medications:
Name of Drug: Type of Adverse Reaction:

_____ _____
_____ _____
_____ _____
_____ _____

Please list all other non-medication allergies: _____

_____

Please list all **PREVIOUS** mental health and/or alcohol and drug treatment this child/youth has received:

Facility	Location	Type of Care (Inpatient, Outpatient, Substance Use)	Month and Year
_____			from _____ to _____
_____			from _____ to _____
_____			from _____ to _____
_____			from _____ to _____

Please list prior and present mental health diagnoses: _____

_____

Have you or others ever been concerned about this child/youth's drinking or drug use? ☐Yes ☐No

If yes, explain: _____

_____

Number of Foster Care placements in the last 18 months: _____

How long in the current placement? _____

In emergency, who can we notify? Name: _____ Relationship: _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Business Phone: _____

Form Completed By: _____ Date: _____

Relationship to Child/Youth: _____

For Office Use Only:

Reviewed By: _____ Initials for Additions: _____ Date: _____

Child Welfare and Juvenile Justice
Child/Youth Referral
Determination of Acuity

When making a referral for mental health services it is important for the Community Mental Health Center to understand how critical the need is for the child/youth to be seen. We would like for you to provide us with your assessment of need by completing the information below.

Child/Youth's Name: _____ Date of Birth: ____/____/_____

Today's Date: _____ Child/Youth's SSN: _____

Please check those behaviors that have been present for this child/youth during the <u>past 7 days</u>. To be identified, the behavior should be outside normal limits for age appropriate expectations:

	Attempted suicide		Persistent anger		Involvement with law enforcement
	Intentional self-injury		Taking a weapon to school		Substance use/abuse
	Attempted/accomplished harm to others		Panic attacks		Agitation
	Threat of harm to self		Debilitating anxiety		Sleep disturbance
	Threat of harm to others		Suspension from school		Refusal to eat
	Marked mood instability		Acts of intimidation against others		Damage to property
	Erratic or bizarre behavior		Running away		Hallucinations
	Intense trauma reactions (e.g., flashbacks)		Defiance		Sexual acting out against others
	Self-care failure		Disorientation (person, place, time, situation)		Short term memory loss
	Incoherent language/thought process		Depression		Anxiety
	Requires constant monitoring for safety		Withdrawal from others		Behavioral Regression
	Dangerous actions with fire		Accidental/Reckless Self-Injury		Persistent confusion
	Abuse to animals		Impulsivity		Other (specify below)

Note: Bold-faced items indicate a need to contact the local CMHC for a potential pre-hospitalization screening. If any bold-faced item is marked and a screening is deemed necessary, this screening should be completed <u>before</u> transferring the child/youth to another placement.

Please describe the child/youth's situation/circumstances that led you to check the above behavioral markers – please be as specific as possible.

_____

_____

_____

_____

_____

In order for us to be able to provide services to this child/youth we will need to speak with someone from your agency (Child Welfare/Juvenile Justice staff assigned to the child/youth case) who has knowledge of the child/youth and can help us complete the necessary documentation about the child/youth's history, prior treatment, and current circumstances so that we can adequately determine their treatment needs. Please list below the name and contact information for the person who will be available at the time we are to see the child/youth.

Name of person completing this form (please print):_____ Phone #:_____

Relationship to child/youth: _____ Employed by: _____

Signature of person completing form: _____ Date: _____

(Revised 3/01/2012)