## Child and Family Treatment and Support Services (CFTSS)

## Referral Form

## INSTRUCTIONS: Please complete as much information as possible to the best of your ability.

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| CHILD’S NAME, (*LAST, FIRST, MI,):* | | **ETHNICITY:**  Black/African American  Asian  Hispanic/Latino  Native Hawaiian/Pacific Islander  Alaska Native  White  American Indian  Other: |
| DATE OF BIRTH:  Click here to enter a date. | GENDER:  Male  Female  Trans  Other |
| SCHOOL DISTRICT: | CHILD ASSIGNED:  504  IEP  BIP |
| INSURANCE CARRIER: | MEDICAID CIN/INSURANCE #: |
| **CHILD IS / HAS BEEN IN FOSTER CARE:**  Current  Previous  None |

**\*\*PLEASE NOTE MEDICAL CONSENTER FOR CHILD**

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| PARENT/GUARDIAN NAME (1): | PHONE NUMBER:  IS TEXTING PREFERRED?  Yes  No | BEST TIME TO CONTACT: |
| EMAIL: | | |
| ADDRESS (INCLUDE CITY, STATE, ZIP CODE):    AM  PM  END TIME:    AM  PM  TOTAL BILLABLE UNITS: | | |

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| PARENT/GUARDIAN NAME (if d): | PHONE NUMBER:  IS TEXTING PREFERRED?  Yes  No | BEST TIME TO CONTACT: |
| EMAIL: | | |
| ADDRESS (INCLUDE CITY, STATE, ZIP CODE):    AM  PM  END TIME:    AM  PM  TOTAL BILLABLE UNITS: | | |

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| With which of the following agencies is the child involved or receiving services? (CHECK ALL THAT APPLY) | |
| Mental Health Agency/Clinic/Provider  Physical Health Care Agency/Clinic Provider  Substance Abuse Agency/Clinic/Provider  Intellectual Disabilities Agency/Clinic/Provider  School/Educational Facility/Staff  Early Intervention | Child Welfare/Child Protective Services  Family Court  Juvenile Court/Corrections/Probation/Police  Kinship Care  Other: |

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| What behaviors initiated the referral for services? (CHECK ALL THAT APPLY) | |
| Conduct/delinquency-related behaviors (physical aggression, extreme verbal abuse, non-compliance, property damage, theft, running away, fire setting, cruelty to animals, truancy, police contact)  Hyperactive and attention-related behaviors  School/educational performance  Depression  Anxiety  Adjustment-related issues (to significant life stress)  Suicide-related thoughts or actions  Self-injury  Sexual behavior problems, sexual assault  Psychotic behaviors (hallucinations, delusions, strange/odd behavior)  Substance use, abuse, and drug dependency  Intellectual disabilities  Learning disabilities | Disordered eating (including anorexia, bulimia)  Sleeping problems  Maltreatment (child abuse and neglect)  Excessive crying/tantrums  Persistent noncompliance  Pervasive developmental disabilities (extreme social avoidance, stereotypes, perseverative behavior)  Specific developmental disabilities (enuresis, encopresis, expressive or receptive speech and language delay)  Separation/attachment problems  Feeding problems (failure to thrive)  Other concerns related to health of child (cancer, illness, or disease related problems)  Excluded from school/childcare due to behavioral or developmental problems  Other: |

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| What is the child’s clinical diagnosis? (Complete if known) |
| ICD-10/DSM-V Code Diagnosis Name  Primary Diagnosis  Secondary Diagnosis  Additional Diagnosis  Assigned by:  Date/Location of Evaluation: |
| Desired Outcome for Services: |
| Family Strengths: |
| Child Strengths/Interests/Hobbies/Activities: |
| Family Informal Supports (e.g., Relatives, Community Organization, School): |
| Additional Information: |

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| REFERRING INDIVIDUAL, TITLE: | | DATE OF REFERRAL:  Click here to enter a date. |
| REFERRING AGENCY/ENTITY: | EMAIL: | PHONE #: |
| AGENCY ADDRESS (INCLUDE CITY, STATE, ZIP CODE): | | FAX #: |

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| PARENT/GUARDIAN SIGNATURE: | DATE:  Click here to enter a date. |
| CHILD SIGNATURE: | DATE:  Click here to enter a date. |
| REFERRAL SOURCE SIGNATURE: | DATE:  Click here to enter a date. |

**PLEASE SUBMIT ALL REFERRALS TO:**

Email: [ManagedCareReferrals@elmcrest.org](mailto:ManagedCareReferrals@elmcrest.org)

**WITH REFERRAL INQUIRES PLEASE CONTACT:**

Danielle Janowsky, LCSWR

Director of CFTSS

Email: [djanowsky@elmcrest.org](mailto:djanowsky@elmcrest.org) Phone: 607.296.4515 x11 Fax: 607.296.4520

