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

## Referral Form

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

|  |  |
| --- | --- |
| 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**

|  |  |  |
| --- | --- | --- |
| PARENT/GUARDIAN NAME (1):       | PHONE NUMBER:      IS TEXTING PREFERRED? [ ]  Yes [ ]  No | BEST TIME TO CONTACT:       |
| EMAIL:       |
| ADDRESS (INCLUDE CITY, STATE, ZIP CODE):     [x]  AM[ ]  PMEND TIME:      [ ]  AM[ ]  PMTOTAL BILLABLE UNITS:       |

|  |  |  |
| --- | --- | --- |
| PARENT/GUARDIAN NAME (if d):       | PHONE NUMBER:      IS TEXTING PREFERRED? [ ]  Yes [ ]  No | BEST TIME TO CONTACT:       |
| EMAIL:       |
| ADDRESS (INCLUDE CITY, STATE, ZIP CODE):     [x]  AM[ ]  PMEND TIME:      [ ]  AM[ ]  PMTOTAL BILLABLE UNITS:       |

|  |
| --- |
| 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:       |

|  |
| --- |
| 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:       |

|  |
| --- |
| What is the child’s clinical diagnosis? (Complete if known) |
|  ICD-10/DSM-V Code Diagnosis NamePrimary 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:       |

|  |  |
| --- | --- |
| 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 #:       |

|  |  |
| --- | --- |
| 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

**WITH REFERRAL INQUIRES PLEASE CONTACT:**

Danielle Janowsky, LCSWR

Director of CFTSS

Email: djanowsky@elmcrest.org Phone: 607.296.4515 x11 Fax: 607.296.4520

