



Initial Referral for Assessment of Suitability of a Child for Residential Treatment

<i>Child Information</i>			
NAME:	MEDICAID NUMBER:	SOCIAL SECURITY NUMBER:	
DATE OF BIRTH:	GENDER: Male <input type="checkbox"/> Female <input type="checkbox"/>		
COUNTY OF ORIGIN:	CIRCUIT:	AREA:	
CURRENT MEDICATIONS:			
Single Point of Access (SPOA) Contact Information			
NAME:	PHONE NUMBER:	FAX NUMBER:	
DSM-IV			
DSM IV DIAGNOSIS:			
AXIS I			
AXIS II			
AXIS III			
AXIS IV			
AXIS V			
Child's Current Living Arrangement			
NAME OF CURRENT LOCATION/CAREGIVER:			
PLACEMENT TYPE: <input type="checkbox"/> In-Patient <input type="checkbox"/> STGH <input type="checkbox"/> Shelter <input type="checkbox"/> Detention Center <input type="checkbox"/> CSU <input type="checkbox"/> Foster Parent <input type="checkbox"/> Relative <input type="checkbox"/> Other:			
DAYTIME PHONE NUMBER:		EVENING PHONE NUMBER:	
ADDRESS:	CITY:	STATE:	ZIP:
Community Based Care Caseworker			
NAME:	PHONE NUMBER:	EMAIL ADDRESS:	
ADDRESS:	CITY:	STATE:	ZIP:

Note: Referral Cannot Be Processed if Information Submitted is Illegible or Incomplete.

Guardian ad litem

NAME:

EMAIL ADDRESS:

PHONE NUMBER:

FAX NUMBER:

Attorney ad litem

NAME:

EMAIL ADDRESS:

PHONE NUMBER:

FAX NUMBER:

Reason for Referral for Residential Treatment (detailed mental health information required in this section)**Desired Outcomes of Residential Treatment****Summary of permanency plan goals for the child, including planned discharge placement****Checklist of required documents (please explain if not attached). This section must be filled out for the referral to be processed.**

- Comprehensive Behavioral Health Assessment, completed within last 18 months
- Mental health treatment history, for at least the last 12 months
- Court Information: Shelter Petition, Shelter Order, Pre-Disposition Report, Case Plan
- Individual Education Plan
- Psychological, Psychiatric, Psychosocial, Psychosexual Evaluations
- Provider Clinical Notes, Multidisciplinary team service plan, including implementation results
- DJJ Information (DJJ, JDC, Probation, etc.)

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Checklist of required documents (please explain if not attached). This section must be filled out for the referral to be processed.

Other (please specify):

Additional Comments or Information

We believe that

_____, a child in the custody of the Department of Children and Families, is emotionally disturbed and may need residential treatment, pursuant to Section 39.407, Florida Statute.

SIGNATURE OF COMMUNITY BASED CASE WORKER

DATE

SIGNATURE OF COMMUNITY BASED SUPERVISOR

DATE

SIGNATURE OF COMMUNITY BASED DIRECTOR

DATE

I certify the referral form and package are complete and that all information will be sent to the Qualified Evaluator upon assignment.

SIGNATURE OF SPOA

DATE

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