

**REFERRAL FOR CHILD AND YOUTH CASE MANAGEMENT SERVICES**

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**PROGRAM REQUESTED:**

- Supportive Case Management                       Intensive Case Management                       Home and Community Based Services Waiver

**Referrals for any residential program licensed by the New York State Office of Mental Health, including Family Based Treatment, Teaching Family Homes, Community Residences, and/or Residential Treatment Facilities, must also be reviewed by the Single Point of Entry. For information on how to make a referral to one of these programs, please call 792-7143.**

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**CLIENT INFORMATION:**

Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ Other Insurance: \_\_\_\_\_

Mother (include name, address, phone): \_\_\_\_\_

Father (include name, address, phone): \_\_\_\_\_

Siblings (include ages): \_\_\_\_\_

Current guardian/custodial adult: \_\_\_\_\_

Lives with:     Parent(s)                       Guardian                       Other: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Please check all that apply:

- Functional limitations in the areas indicated:                       Self-care                       Family life
- Social relationships                       Learning ability                       Self-direction
- Met criteria for a rating of 50 or less on the Children’s Global Assessment Scale in the past year
- Meets criteria for a rating of 50 or less on the Children’s Global Assessment Scale currently
- Experienced one of the following in the last 30 days:
  - Serious suicidal symptoms or other life-threatening destructive behaviors;
  - Significant psychotic symptoms; and/or
  - Behavioral problems causing a risk of personal injury or significant property damage.

Referral Source: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reason for referral at this time (please state specifically how these services will benefit the child or youth): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**PSYCHIATRIC INFORMATION:**

Clinical Treatment Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_ Psychiatrist: \_\_\_\_\_

Diagnosis : Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

Medications (please list dosage and attach additional sheets if necessary): \_\_\_\_\_

Does the child or youth take medications as prescribed? Yes  No

**SUICIDE/HOMICIDE RISK:** Yes  No  Unknown

Please describe recent suicidal ideation, suicide attempts or homicidal ideation: \_\_\_\_\_

Please describe past history of suicidal ideation, suicide attempts or homicidal ideation: \_\_\_\_\_

**PSYCHIATRIC HOSPITALIZATION:** Unmet Needs  Needs Met  Unknown

Currently inpatient? Yes  No  Admit date: \_\_\_\_\_ Anticipated D/C date: \_\_\_\_\_

Please list any previous psychiatric hospitalizations: \_\_\_\_\_

**MENTAL HEALTH TREATMENT:** Unmet Needs  Needs Met  Unknown

Please list any previous outpatient treatment, including current: \_\_\_\_\_

Brief history of illness: \_\_\_\_\_

Does the child or youth have a history of violence to self or others? Yes  No  If yes, please explain.

Behavioral Symptoms (check all that apply):

<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Phobias	<input type="checkbox"/> Suicidal ideation or attempt
<input type="checkbox"/> Aggression	<input type="checkbox"/> Cruelty to animals
<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Bed-wetting or soiling
<input type="checkbox"/> Developmental delays	<input type="checkbox"/> Inappropriate sexual behavior
	<input type="checkbox"/> Property destruction
	<input type="checkbox"/> Fire-setting
	<input type="checkbox"/> Physical complaints
	<input type="checkbox"/> Other: _____

**HEALTH CARE:** Unmet Needs  Needs Met  Unknown

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

**SUBSTANCE ABUSE:** Unmet Needs  Needs Met  Unknown

Please list past and present use and treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatment Provider: \_\_\_\_\_ Clinician: \_\_\_\_\_ Phone: \_\_\_\_\_

**LEGAL INVOLVEMENT:** Unmet Needs  Needs Met  Unknown

History of violence, PINS involvement, Juvenile Delinquent status, Court involvement, and probation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact (probation officer, PINS worker, etc.): \_\_\_\_\_ Phone: \_\_\_\_\_

**FINANCIAL MANAGEMENT:** Unmet Needs  Needs Met  Unknown

Check if applicable: SSI  Application pending for: Medicaid  SSI

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_ Other Insurance: \_\_\_\_\_

Please list any financial management needs, including SSI application and/or family income source: \_\_\_\_\_

\_\_\_\_\_

**LIVING ARRANGEMENT:** Unmet Needs  Needs Met  Unknown

History of out-of-home placement:  Foster Care  Group Home  RTF  Other: \_\_\_\_\_

Please list current living arrangement: \_\_\_\_\_

\_\_\_\_\_

**EDUCATIONAL FUNCTIONING:** Unmet Needs  Needs Met  Unknown

<input type="checkbox"/> Academic functioning below grade level	<input type="checkbox"/> Special education services (Classification: _____)
<input type="checkbox"/> School suspensions and/or expulsions	<input type="checkbox"/> Aggressive towards teachers
<input type="checkbox"/> Conflict with peers	<input type="checkbox"/> Unresponsive to teacher direction
<input type="checkbox"/> Fails to participate	<input type="checkbox"/> Lacks friends
<input type="checkbox"/> Inconsistent attendance	<input type="checkbox"/> Currently on home instruction

Summary of school performance and history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TRANSPORTATION:** Unmet Needs  Needs Met  Unknown

Please list current transportation needs: \_\_\_\_\_

**SOCIAL SUPPORTS/FAMILY FUNCTIONING:** Unmet Needs  Needs Met  Unknown

Supports/social clubs: \_\_\_\_\_

Leisure time activities: \_\_\_\_\_

Identified needs: \_\_\_\_\_

- |   |   |
|---|---|
| <input type="checkbox"/> Supportive family unable to cope with child's disability | <input type="checkbox"/> Parent(s) unable to control child's behavior                 |
| <input type="checkbox"/> Family violence  | <input type="checkbox"/> Substance abuse by parent(s)                                 |
| <input type="checkbox"/> Parent(s) have criminal record                           | <input type="checkbox"/> Parent(s) are intellectually limited                         |
| <input type="checkbox"/> Parent(s) inconsistent with treatment and/or medication  | <input type="checkbox"/> Current CPS involvement                                      |
| <input type="checkbox"/> Psychiatrically ill parent(s)                            | History of hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Psychiatrically ill sibling(s)                           | History of hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Is child/youth aware of this referral? Yes  No  Is child/youth interested in services? Yes  No

Please list child or youth and family strengths and skills: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>SERVICE NEEDS:</b>	Needs Met	Low Priority	High Priority
Psychiatric Services:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Services:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living Arrangements:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benefits/Financial:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work/School:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social/Family Relationships:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisis/Safety Planning:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please add any additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Required information:**

- Consent for release of information
- Psychiatric evaluation (most recent)
- Treatment plan (most recent)
- Admission/discharge summaries (most recent)

**Please send form and required information to:**

SPOE Coordinator, Office of Community Services  
230 Maple Street  
Glens Falls, NY 12801  
Phone: (518) 792-7143 Fax: (518) 792-7166