# Referral Form

## Referral to community-based mental health services:

Please complete this form to the best of your knowledge and return to the Cambia Hills Community-based Program:

**Fax:** 218.623.6475 / **E-mail**: swildwood@thehillsyfs.org / **Phone**: 218.623.6476

You will be contacted within three business days to verify receipt of your referral. Thank you for choosing Cambia Hills!

## Child's Information

| | | | | |
|---|---|---|---|---|
| Full Name | Nickname | | Gender identity: ☐ Male ☐ Female ☐ ☐ Prefer not to say | |
| Date of Birth | Place of Birth | | Social Security No. | |
| Last Known or Permanent Address | City | | State | Zip |
| Home Phone | Current Placement or location | | Age | |
| Race/Ethnicity | Primary Language | | Spiritual or religious affiliation | |
| Tribal Affiliation, if any | Is child adopted? ☐ Yes ☐ No | Age at first adoption? | # finalized adoptions? | Is child a State Ward? ☐ Yes ☐ No |
| Medical Insurance Provider and Policy No. Primary: | | Secondary: | | |

## Child's Profile

| |
|---|
| What are the presenting problems in your perspective? |
| What is the history of or contributing factors to the child's problems? |
| What are some of the child's assets, strengths, interests or abilities? |

## Child's Profile (cont'd)

List child's current medications.

Any health concerns or physical limitations?

☐ Yes ☐ No If yes, explain:

Any cognitive, developmental, or IQ concerns?

☐ Yes ☐ No If yes, explain:

Any school-related problems

☐ Yes ☐ No If yes, explain:

Currently suicidal? Any history of suicide or self-harm? Any hospitalizations for mental health?

☐ Yes ☐ No If yes, explain:

Any chemical abuse? Any treatment interventions?

☐ Yes ☐ No If yes, explain:

Any history of abuse, neglect, or trauma?

☐ Yes ☐ No If yes, explain:

Any safety concerns of child being vulnerable with his/her peers?

☐ Yes ☐ No If yes, explain:

Any history of this child victimizing or harming others?

☐ Yes ☐ No If yes, explain:

Any history of running away?

☐ Yes ☐ No If yes, when:

## History of Services Delivered

Outpatient Services (therapy, day treatment, etc.)

| Name of Agency | Dates of Service | Result |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Residential/Inpatient Services

| Name of Agency | Dates of Service | Result |
|---|---|---|
| | | |
| | | |
| | | |

## Delinquency History? ☐ Yes ☐ No

| Current and Prior Offenses | Class/Degree of Offense | Offense Date | Disposition |
|---|---|---|---|
| | | | |

## Services You Are Requesting

What treatment goals do you have for your child (or client)?

What additional services does your child/client need?

## Contact Information

**Parent/guardian**

| | | | |
|---|---|---|---|
| (1) Parent/Guardian name | Parent's Date of Birth | Does child live with this parent? ☐Yes ☐No | |
| Street Address | City | State | Zip |
| Phone | Other Phone | Email | |
| (2) Parent/Guardian name | Parent's Date of Birth | Does child lives with this parent? ☐Yes ☐No | |
| Street Address | City | State | Zip |
| Phone | Other Phone | Email | |

Who has custody of the child?

Any restrictions on either parent's involvement?

☐ Yes ☐ No If yes, what?

Will the parent(s/guardian(s be supportive of mental health services?

☐ Yes ☐ No If no, why?

**Other Professionals Currently Working with this Child**

| | | | |
|---|---|---|---|
| Agency | Worker's Name | Phone | Involved in treatment? ☐ Yes ☐ No |
| Agency | Worker's Name | Phone | Involved in treatment? ☐ Yes ☐ No |

## Contact Information (cont'd)

| Current School | | |
|---|---|---|
| Name of Current School (not district): | School Contact for this Child: | Phone |
| Child's current grade level? | Does the client have an IEP? (please send)<br>☐ Yes ☐ No | If yes, primary disability? |

## Supporting Documentation to be Provided (as available/applicable)

Supporting documentation is needed to help us make an informed decision on how we can best meet your child's needs. In general, documentation from a licensed mental health professional that includes a history, diagnosis, family/social information and a recommendation to the appropriate level of care (residential treatment mental health or day treatment) is needed. This is usually found in a standard diagnostic assessment or psychological evaluation. This information must be current (within 6 months for the residential treatment mental health program; within 1 year for day treatment). The more supporting information you are able to send, the better. Supporting information is needed in order for the referral to be reviewed. Please note that you may be asked to sign a release of information for other agencies to share documentation with us.

| | |
|---|---|
| ☐ Psychological or Diagnostic Assessments | ☐ Individual Education Plan (IEP) |
| ☐ Psychiatric Reports | ☐ Program/Hospital Discharge Reports |
| ☐ Social/Family Assessments | ☐ Substance Abuse Assessment (Rule 25) – Most Recent |
| ☐ Court Reports | ☐ Copy of Out-of-Home Placement Plan |
| ☐ Copy of Court Orders | ☐ Voluntary Placement Agreement |
| ☐ CASII or YLSI assessment | ☐ Other: |

Use this space for any additional information you wish to share.