



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:** community@thehillssyfs.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!

<i>Child's Information</i>				
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age at first adoption?	# finalized adoptions?	Is child a State Ward? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Insurance Provider and Policy No. Primary:		Secondary:		

<i>Child's Profile</i>
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address	City	State	Zip
Phone	Other Phone	Email	
Who has custody of the child?			
Any restrictions on either parent's involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what?			
Will the parent(s)/guardian(s) be supportive of mental health services? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?			

Other Professionals Currently Working with this Child

Agency	Worker's Name	Phone	Involved in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agency	Worker's Name	Phone	Involved in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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| <input type="checkbox"/> Psychological or Diagnostic Assessments
<input type="checkbox"/> Psychiatric Reports
<input type="checkbox"/> Social/Family Assessments
<input type="checkbox"/> Court Reports
<input type="checkbox"/> Copy of Court Orders
<input type="checkbox"/> CASII or YLSI assessment | <input type="checkbox"/> Individual Education Plan (IEP)
<input type="checkbox"/> Program/Hospital Discharge Reports
<input type="checkbox"/> Substance Abuse Assessment (Rule 25) – Most Recent
<input type="checkbox"/> Copy of Out-of-Home Placement Plan
<input type="checkbox"/> Voluntary Placement Agreement
<input type="checkbox"/> Other: |
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Use this space for any additional information you wish to share.