Child Targeted Case Management Referral Form

NAME: ______________________________ SS#: __________________ DATE: ________

DOB: _______________________ GENDER: ________ PHONE: ______________________

ADDRESS: ____________________________________ CITY: _______________________

STATE: ______________________________________ ZIP CODE: ____________________

GUARDIAN/CAREGIVER: ____

INSURANCE: _________________________________ ID# __________________________

SCHOOL: ____

THERAPIST: __________________________ CONTACT NUMBER: ______________________

PSYCHIATRIST: ________________________ CONTACT NUMBER: ______________________

REFERRAL TYPE:
□ **SEVERE EMOTIONAL DISABILITY (IMPACT)**
□ **SUBSTANCE USE DISORDER (U-TURN/OTHER SUD SERVICES)**

DIAGNOSIS (Primary): ____________________________________
DIAGNOSIS (Secondary): ____________________________________

DURATION: (check all that apply)

□ Clinically significant symptoms have persisted in the individual for a continuous period of at least two (2) years
□ The individual has been hospitalized more than once in the past two (2) years
□ There is a history of one or more episodes with marked disability and it is expected to continue for a two (2) year period of time

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REASON FOR REFERRAL: (How has the individual's role, personal relationships, daily living skills, physical health needs, or cognitive functioning been impaired as a result of their illness)

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STRENGTHS: (Please list strengths and natural support systems that can be part of the case management service)

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NEEDS: (Please list areas of concern that will benefit from case management intervention)

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DCBS INVOLVEMENT: □ YES □ NO WORKER: ____

COURT INVOLVEMENT: □ YES □ NO WORKER: ____

NEEDS INTERPRETER: □ YES □ NO LANGUAGE: ______________________________________

REFERRAL SOURCE: ____________________________________ PHONE: ___________________

REFERRING AGENCY: ____

FOR INTERAL USE ONLY

DATE RECEIVED: _______________________ DATE ASSIGNED: ____________________________

CASE MANAGER: ______________________________________

CONSULTATION WITH REFERRAL SOURCE:

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SIGNATURE: ____ DATE: __________________