REFERRAL

CSA Form - 1

YOUTH'S NAME: __________________ DOB: ____/____/____ AGE: ______DATE OF REFERRAL: ____/____/____

REFERRER INFORMATION:

PRINT name: ________________________________ Phone Number: (____)_____-__________ E-mail: ______________________

PRINT agency: ________________________________ Role: ___________________

Please attach most recent: ☐ Assessment ; ☐ Service Plan; ☐ Safety Plan; ☐ Ed Plan; ☐ Other: ____________________________

YOUTH INFORMATION:

Gender ☐ F ☐ M Social Security # ____ - ____ - ____ Race/Ethnicity: _____________ Primary Language __________________

Insurance (check one): ☐ Network Health; ☐ Beacon Strategies (NHP, Fallon, BMC); ☐ MBHP Member ID # _____________________

Youth currently resides: ☐ Home; ☐ Foster Home ☐ Shelter:_________ ☐ Treatment Facility:___________ ☐ Other:_______________

Date of admission to current facility (as applicable): ____/____/____ Date of expected discharge ____/____/____

Address of current residence: ________________________________Apt.____ City _____________________ Zip Code ______________

Residence Contact name: ________________________Contact Number: (___) ____-_______ Alternative Number: (___) ____-_____

Is youth enrolled in school? ☐ Y ☐ N. If yes, name of school: __________________________ Grade: _______ IEP ☐ Yes ☐ No

School address: __________________________ City _____________________ Zip Code ___________ Number: (____) ____-_____

PARENT/GUARDIAN INFORMATION:

Guardian Name:____ Primary Language: _______________________________

Guardian Name:____ Primary Language: _______________________________

Address (if different then youth's): ___________________Apt.____ City __________ Zip Code _______Contact Number: (___) ____-______

Description of family make up/who lives in home: ____

____

____

Are there any special languages, cultural, medical needs for this family? ☐ Y ☐ N.

If yes, please explain:____

Strengths and special interests of the youth and family:

____

____

____

RELEVANT INFORMATION:

Presenting Problem and/or specific goals to be addressed:

____

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____

Brief summary of prior assessments completed:

____

____

RELEVANT INFORMATION (cont'd):

- Please check if the youth has had other out of home placement(s) ☐ Y ☐ N
- History of psychiatric hospitalization(s) ☐ Y ☐ N Most current psychiatric hospitalization date: ____/____/____
- Diagnosable mental, behavioral or emotional disorder ☐ Y ☐ N
- Most current diagnosis: (include DSM-IV-TR Code)

AXIS I: ______________________________________ AXIS II: ____

AXIS III: _____________________________________ AXIS IV: ____

AXIS V: _____________________________________

Brief family history/dynamics related to current problem:
If you have attached updated assessment, service plan or risk plan, write "see attached" below.
Include any history of mental illness, substance abuse, domestic violence, sexual or physical abuse, cultural factors, and medical history.

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POTENTIAL TEAM MEMBERS - CURRENT SUPPORT SYSTEM/AGENCY INVOLVEMENT:

Provider	Contact Person	Agency	Phone Number
PCP			
Therapist			
DCF			
DMH			
Psychiatrist			
Natural Support(s)			
Other			

MEDICATIONS: Compliant ☐ Y ☐ N

Name of Medication(s)	Dose

The family understands the Intensive Care Coordination and Family Support role and agrees to work with the CSA voluntarily ☐ **Y** ☐ **N**

Family understands that an Eliot staff member will contact them and the above support system and/or agency involvement to learn more about the youth to determine whether she or he meets the eligibility criteria, will contact the referrer for more information and will contact MassHealth to confirm her or his MassHealth eligibility. ☐ **Y** ☐ **N**

Parent/ Guardian signature ________________________________ Signature Youth over 18: ___________________________________