**Referral Form**

| **Date of Referral:** | **Patient Name:**       Patient on an 504 Plan or IEP Plan: | |
| --- | --- | --- |
| **Date of Birth:** | **SS#:**    -  - | **School Attending:** |
| **Patient’s Guardian Phone #:**    - | | **Referral Source:** |
| **Phone # of Referral Source:**    -     x | | **Patients Guardian’s Name**: |
| **Insurance ID Number:** | | **Current Diagnosis:** |
| **Have the caregivers been informed about the requirements for family involvement?** | | ☐ Yes ☐ No |
| **PARENT/CAREGIVER’S RELATIONSHIP TO CHILD** | | ☐ Parent ☐Foster Parent ☐ Guardian ☐ Relative or ☐ Other: |
| CURRENT AND PAST BEHAVIORAL HEALTH TREATMENT PROVIDERS/AGENCIES: | |  |
| Currently on Medications? | | ☐ Yes ☐ No Please Identify the current and past medications: |
| Most recent psychiatric hospitalizations: Provide Dates and Reason for hospitalizations | |  |

**Reason for Referral:**

| **Difficulty making transition:** | ☐ new student/freshman | | | ☐ new program | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Social problems:** | ☐ aggressive | | ☐ shy | ☐ overactive | | ☐ other |
| **Achievement problems:** | ☐poor grades | | ☐ poor skills | ☐ low motivation | | |
| **Program Being Referred To** | ☐Outpatient Therapy | | ☐ School Based Therapy | ☐ Psychiatric Evaluation/Medication Management | | |
| **Major psychosocial or mental health concern:** | | | | | | |
| ☐drug/alcohol abuse | | ☐depression/suicide | | | ☐grief | |
| ☐dropout prevention | | ☐gang involvement | | | ☐pregnancy support | |
| ☐eating problems | | ☐physical/sexual abuse | | | ☐neglect | |
| ☐reactions to chronic illness | | ☐self esteem | | | ☐family/relationship probs | |
| ☐anxiety/phobia | | ☐legal problems | | | ☐other | |
| **Current Related Service hours receiving in school now according to 504, IEP Plan, or SST Plan:** | | | | | | |
| **Other specific concerns:** | | | | | | |
|  | | | | | | |

**Current school functioning and desire for assistance:**

| **Absent from school:** | ☐ seldom | ☐ 1/month | | ☐ 2-3/month | | ☐ 4+/month |
| --- | --- | --- | --- | --- | --- | --- |
| **Overall academic performance:** | ☐poor grades | | ☐ poor skills | | ☐ low motivation | |
| **Has the student/family asked for:** | Information about service ☐Y ☐N  An appointment to initiate help ☐Y ☐N  Someone to contact them to offer help ☐Y ☐N | | | | | |
| **If you have information about the cause of a problem or other important factors related to the situation, briefly note them here (use the back if necessary).** | | | | | | |
|  | | | | | | |

| ***Symptoms*** | ***Current*** | ***History*** | ***Explanation of Checked Symptoms*** |
| --- | --- | --- | --- |
| ***Self-injurious Others*** | ☐ | ☐ |  |
| ***Aggressive Towards*** | ☐ | ☐ |  |
| ***Bedwetting/Soiling*** | ☐ | ☐ |  |
| ***Developmental Delays*** | ☐ | ☐ |  |
| ***Limitations*** | ☐ | ☐ |  |
| ***Abuse Cognitive*** | ☐ | ☐ |  |
| ***Truancy Substance*** | ☐ | ☐ |  |
| ***Anxiety Running Away*** | ☐ | ☐ |  |
| ***Tantrums Depression*** | ☐ | ☐ |  |
| ***Stealing Lying Temper*** | ☐ | ☐ |  |
| ***Sexualized Behaviors*** | ☐ | ☐ |  |
| ***Homicidal Ideation*** | ☐ | ☐ |  |
| ***Suicidal Ideation*** | ☐ | ☐ |  |
| ***Psychotic Symptoms*** | ☐ | ☐ |  |
| ***Destroying Property*** | ☐ | ☐ |  |

***Please complete this form electronically and/or print it: email to*** [***help@leosupportct.com***](mailto:help@leosupportct.com) ***or mail to P.O. Box 380-322, East Hartford, CT 06138. Or fax to 860-249-0975***

**IN-HOME SERVICES TREATMENT REQUEST**

Facility Requesting Authorization: The Latin Enrichment Organization, LLC

Submitted By: Tammy Mathieu Contact Number: 203-641-8979

Supervisor: Sarah MacDonald Contact Number: 860-249-0975

Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Anthem ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Assessment: \_\_\_\_\_\_\_\_ Who referred member ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Type:

**IIBHS X** MDFT\_\_\_\_\_\_\_\_\_\_\_\_\_ MST \_\_\_\_\_\_\_\_\_\_\_\_\_ IICAPS \_\_\_\_\_\_\_\_\_

Service Codes Requested and Number of Units per Code:

H0004 – Behavioral Health Counseling and Therapy \_\_\_\_\_\_\_\_\_ units

H0006 - Alcohol and/or drug services: case management \_\_\_\_\_\_\_ units

H0023 – Behavioral Health Outreach Service \_\_\_\_\_\_\_\_ units

Admission date: \_\_\_\_\_\_\_\_\_\_\_\_ Anticipated discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Information:

Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current Medications (list name, dose, duration): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Prior intensive treatment history (list facility, dates, level of care, issue (ED, SA, MH)): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Discharge plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_