**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 ☐NAn appointment to initiate help ☐Y ☐NSomeone 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*** ***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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