Intensive Home-based Clinical Services – Universal Referral Form

***Please provide releases for ALL guardians and necessary services**

Date of Referral:

Name of Youth: **DOB:** **Gender:**

School:

Parent(s)/Guardian: **Relationship:**

Address: **Apt. #**

Home #: **Cell #:** **Work #:**

EMAIL address:

Need appointment after 5pm? Yes ☐ No ☐ Best time to be reached by phone:

Is youth living with family: Yes ☐ No ☐ If no, who and where is youth residing:

Family Constellation (i.e. who's living at home):

_ PPS/CPS history or current involvement? Yes ☐ No ☐
If yes: Current Investigation: Yes ☐ No ☐ Preventive Services: Voluntary ☐ Mandated ☐ Case Worker's Name:

Connections Case Name: **Connections Case #:**

_ Does youth have a Mental Health Diagnosis? Yes ☐ No ☐
If yes, please provide details:

Has youth ever been to CPEP or hospitalized? Yes ☐ No ☐
If yes, please provide details:
Risk factors: Suicidal Ideation: Present ☐ Past ☐ No Indication ☐
Self-Harming Behaviors (e.g. cutting): Present ☐ Past ☐ No Indication ☐

Past Home-based Clinical Services? Yes ☐ No ☐
If yes, please provide details:

Current Services/Treatment Providers/Probation:

Reason for Referral (Nature of Concern) and Desired Outcome of Treatment:

Differentiation/Eligibility Checklist:

Is entire family willing to participate in counseling/therapy? Yes ☐ No ☐ If no, please provide details:

Is English the family's primary language? Yes ☐ No ☐
If no, please provide details:

Additional Information:

Substance Use/Abuse: Youth: Yes ☐ No ☐ Parent(s): Yes ☐ No ☐

Cognitive Issues: Youth: Yes ☐ No ☐ Parent(s): Yes ☐ No ☐

Trauma History: Youth: Yes ☐ No ☐ Parent(s): Yes ☐ No ☐
If yes, please provide details:

Aggression/Violent Behavior: Youth: Yes ☐ No ☐

Domestic Violence History: Yes ☐ No ☐ Current: Yes ☐ No ☐ Suspected: Yes ☐ No ☐

Sexual abuse: Yes ☐ No ☐ Suspected: Yes ☐ No ☐
If yes, youth is: Victim ☐ Perpetrator ☐ Both ☐

Any pets in the home? Yes ☐ No ☐ If yes, please specify:
Any safety issues to be aware of:

Family Statement: What else would you like us to know about your family/youth?

Youth Statement: What are you hoping to get out of this home-based program?

Form Completed By: _____ Phone: _____ EMAIL: _____

Attachments: Assessment: ☐ Specify: _____ Consent/Release: ☐

Fax Form with attached Release to Circare at 315-472-0084 or email to Cheryl Portorsnok at cportorsnok@cir.care *You will be notified when referral has been received.

For CIRCARE use only: Send Referral to: MST ☐ FFT ☐ HBCI ☐

Referral sent by: _____ Date: _____

Intensive Home-based Clinical Services

Parent/Guardian Consent to Release Information:

Child/Youth's Name: _____ DOB: _____

I hereby authorize the individual completing the attached referral form (_____) to share this information and any accompanying assessment tool results regarding my child/youth with the ACCESS Team's Clinician or his/her designee for the purpose of determining the appropriate referral for Intensive Home-based Clinical Services.

I also authorize the ACCESS Team's Clinician or his/her designee to share this information with the agency to which my youth/family is referred for services. In turn, I authorize the supervisor or his/her designee (see attached list) of the program to which my youth/family is referred to receive/disclose information from/to the ACCESS Team's Clinician or his/her designee and the individual completing the attached referral form (named above). This release will remain in effect until my youth/family is enrolled in that agency's program.

I also elect, should I choose to do so, to **not** have this information shared with the agency or agencies I write-in below and understand that doing so will eliminate their respective home-based clinical program(s) from consideration. Currently, the agencies providing Intensive Home-based Clinical Services are: *Onondaga Case Management Services, The Salvation Army, and Liberty Resources*.

_____ _____

_____ _____

*Note: listing any or all of the above-named agencies will effectively eliminate their program from consideration

☐ I am in need of translation services and give consent for ACCESS team to utilize and communicate with MAMI translation services.

_____

Print Name of Parent/Guardian

_____ _____

Parent/Guardian Signature Date

_____

Print Name of Witness

_____ _____

Witness Signature Date

Fax Form to CIRCARE at 315-472-0084 Cheryl Portorsnok at

cportorsnok@cir.care