

Lincoln County Systems of Care

112 E. 7th Street (Physical Address)

112 N. McKinley (Mailing Address)

Chandler, OK 74834

405-258-2178



REFERRAL PACKET

Attached is a referral packet to be completed by the caregiver or provider of services for a child that is extremely emotionally distressed. The services provided to the family will involve the family, extended family members, friends, clergy, school personnel, various social service providers, and others identified by the child or family as being supportive.

Goals of Chandler Systems of Care:

- 1. We hope to assist the family in managing crises more effectively, reduce the frequency of personal crises occurring in the home, and improve relationships among family members and others supportive of the family.**
- 2. We hope to assist the family in developing a strong support system that can be relied on long after the family has graduated from Lincoln County Systems of Care.**

If you believe that Lincoln County Systems of Care would benefit a child in your care, in your community, or for whom you are a provider of services, please fill out the attached sheets to provide us with information about the child. Lincoln County Systems of Care will contact you for a follow-up shortly after the referral is received.

After the follow-up, the referral will be taken to the Lincoln County review team at which time a determination will be made to either accept the child or assist the child and family in finding alternative services. The referral source and referred family will be promptly notified of the review team's decision.

**Please Return Referral to: Valerie Taylor, *Care Coordinator*
Red Rock BHS / Lincoln County Systems of Care
112 N. McKinley
Chandler, OK 74834**

Phone: (405) 258-2178 (fax) 258-2478 (cell) 258-8053

Oklahoma Systems of Care Initiative Referral Form

Referring Agency: _____ Date of Referral: ____ / ____ / ____

Referring Person: _____ Phone: _____

Original referral source, if different from above: _____

Youth Information

Name: _____ SSN: ____ - ____ - ____ Date of Birth: ____ / ____ / ____ Age: ____

Race/Ethnicity: _____ Sex: ____ School: _____ School Phone: _____

Caregiver Name: _____ Relationship to Child: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Alternate Phone Number _____ Relationship _____

Indicate if the youth is:

DHS: Involved In custody DHS worker/phone: _____ / _____

OJA: Involved In custody OJA worker/phone: _____ / _____

School: Grade _____ Receiving Special ED Services Special ED Category _____

In substance abuse or mental health treatment Agency: _____ Phone: _____

Receiving other services (specify): _____

On medications (please list): _____

Prescribing Physician: _____ Date Last Seen: _____

Initial Screening – Please check all that apply

- The youth has behavioral/emotional symptoms that suggest a diagnosable emotional disorder.
- The youth has a significant difficulty that has lasted or is expected to last for a year or more due to her/his serious emotional disturbance.
- The youth needs, has received or has requested services or support from two or more systems.
- The youth is at risk of out-of-home placement or out-of-school placement due to the impact of the serious emotional and/or behavioral disturbance.
- The youth and her/his parent; guardian or foster parent resides in a county served by the Oklahoma Systems of Care Initiative.
- The family volunteers for this service and agrees to participate actively.

General mental health / diagnosis comments

Psychiatric Evaluation Date: _____ **Evaluated By:** _____

Risk Factors (please check all that apply and add comments for explanation)

Youth Factors

- | | |
|---|--|
| <input type="checkbox"/> Runaway / leaving home without permission | <input type="checkbox"/> Chronic illness |
| <input type="checkbox"/> Withdrawal from family, social activities | <input type="checkbox"/> Self-abusive behavior |
| <input type="checkbox"/> Recent dramatic changes in eating habits, sleep pattern or body weight | <input type="checkbox"/> Repeated incidents of lying, stealing, property destruction |
| <input type="checkbox"/> Age or developmentally inappropriate bed-wetting or soiling | <input type="checkbox"/> Physical aggression toward authority figures, family members, peers |
| <input type="checkbox"/> Inappropriate sexual behavior | <input type="checkbox"/> Intentionally hurts others |
| <input type="checkbox"/> Perpetrator of sexual abuse | <input type="checkbox"/> Intentionally hurts animals |
| <input type="checkbox"/> Victim of sexual abuse | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Victim of physical abuse | <input type="checkbox"/> Involvement in criminal activity |
| <input type="checkbox"/> Use or abuse of alcohol or drugs | <input type="checkbox"/> Declining school grades, truancy, poor attendance |
| <input type="checkbox"/> Attempted suicide or suicidal thoughts | <input type="checkbox"/> School suspensions / expulsions |
| <input type="checkbox"/> Hallucinations – aural, visual or tactile | <input type="checkbox"/> Developmental delays |
| <input type="checkbox"/> History of inpatient psychiatric hospitalization(s) | <input type="checkbox"/> History of neglect |

Caregiver / Family Factors

- | | |
|---|---|
| <input type="checkbox"/> Chronic physical illness in family

<input type="checkbox"/> Family history of mental illness, psychiatric hospitalization or substance abuse

<input type="checkbox"/> Suicide attempts

<input type="checkbox"/> Victim of physical abuse (other than youth)

<input type="checkbox"/> Victim of sexual abuse (other than youth) | <input type="checkbox"/> Parental incarceration

<input type="checkbox"/> History of domestic violence

<input type="checkbox"/> Poverty

<input type="checkbox"/> Other children in foster care

<input type="checkbox"/> Youth exposed to substance abuse in the home |
|---|---|

Members of the Youth's Household

Name	Relation to Youth	Age	Name	Relation to Youth	Age

Other Information

How can this youth and her/his family benefit from their involvement with Systems of Care? _____

What other information about the youth and her/his family do you feel would be helpful to Systems of Care staff?

**RED ROCK BEHAVIORAL HEALTH SERVICES
AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION**

I, _____ (Name of Client) _____ (Date of Birth) _____ (Social Security #) _____ (Chart #)

HEREBY AUTHORIZE: _____ TO COMMUNICATE & EXCHANGE INFORMATION WITH:
RED ROCK BEHAVIORAL HEALTH SERVICES _____ (Referral Source) _____
Lincoln County Systems of Care / Wraparound _____
112 N. McKinley, Chandler, OK 74834 (405) 258-2178 _____

the information indicated below for the following purpose(s) (Client must initial or check):

_____ Treatment planning _____ Responsible Party/Family Member/Emergency Contact
_____ Submission of court/progress reports _____ Follow-up
_____ Insurance Eligibility/health benefits _____ Other (specify) Referral to Lincoln County SOC

PERIOD OF TIME COVERED BY INFORMATION TO BE RELEASED: _____

METHOD OF RELEASE (please check all that apply): Fax Written Verbal Video Audio

REPORTS TO BE FURNISHED (Client must initial or check):

_____ Psychosocial Assessment _____ Medication Record _____ Psychological Testing
_____ Health & Medication History _____ Progress Notes _____ Discharge Summary
_____ Alcohol & Other Drug Information _____ Treatment Plans _____ Other Referral

Notice to recipients of alcohol and drug abuse records:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

The information you authorize for release may include records which may indicate the presence of a communicable or non-communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, tuberculosis, and the human immunodeficiency virus (HIV), also know as AIDS or Acquired Immune Deficiency Syndrome (63 O.S. § 1-502-2).

Clients referred by the Criminal Justice System – The information disclosed may only be redisclosed to carry out the recipient's official duties with regard to the client's criminal proceeding in reference to which the consent to release confidential information was made by the client.

I understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations. Federal regulations prohibit Red Rock Behavioral Health Services from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. I also understand that I (or my legally authorized representative) may revoke this consent (in writing) at any time by contacting a Red Rock staff member unless action has already been taken. A photocopy of this authorization shall be considered as valid as the original. This consent will expire when all third (3) party payer claims are satisfied or not to be exceeded one year from the date signed. (For clients who have been referred by the Criminal Justice System, this consent expires no later than the date of final disposition of any criminal proceedings).

I further understand that my treatment services are not contingent upon, or influenced by, my decision to permit the information release, and by signing below, I indicate that my consent to the release of this information is given freely and voluntarily.

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Client's Signature

Date

Signature of Witness

Date

Signature of parent, guardian, or authorized representative
(Relationship to Client _____)

Date