

## REFERRAL FORM

Enclosed is a referral packet to be completed by the caregiver or provider of services for a child with extreme emotional distress. The services provided to the family will involve extended family members, family, friends, clergy, school personnel, various social service providers, and others identified by the child or family as being supportive.

Goals of Logan County Systems of Care:

1. We hope to assist the family in managing crises more effectively, reduce the frequency of the 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 Logan County Systems of Care.

If you believe that Logan 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. Logan 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 Logan County Systems of Care 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: Kara Walters, Project Director  
P.O. Box 1621  
Guthrie, OK 73044  
Or fax to (405) 293-9684  
Questions? Call (405) 293-9098  
Email: [kwalters@logancommunityservices.org](mailto:kwalters@logancommunityservices.org)

# Logan County Systems of Care

P.O. Box 1621 – Guthrie, OK 73044

405.293.9098 office 405.293.9684 Fax

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## 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: \_\_\_\_\_ Ethnicity/Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

School: \_\_\_\_\_ School Phone: \_\_\_\_\_

Caregiver(s) Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

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: \_\_\_\_\_

Is client currently seeing a counselor?  Yes  None reported If yes, where? \_\_\_\_\_

Receiving other services (specify):  
\_\_\_\_\_  
\_\_\_\_\_

Client taking medication(s):  Yes  None Reported

If yes, list those medications client is taking:

<u>Medication</u>	<u>Strength</u>	<u>Dosage</u>	<u>Length Taken</u>	<u>Reason</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Prescribing Physician: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

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## **Previous Behavioral Health Treatment**

Yes  None Reported If yes, provide the following:

<u>Date</u>	<u>Type</u>	<u>Reason</u>	<u>Facility/Counselor</u>
_____	<input type="checkbox"/> Crisis int. <input type="checkbox"/> Out pt. <input type="checkbox"/> In pt. <input type="checkbox"/> Other	_____	_____
_____	<input type="checkbox"/> Crisis int. <input type="checkbox"/> Out pt. <input type="checkbox"/> In pt. <input type="checkbox"/> Other	_____	_____
_____	<input type="checkbox"/> Crisis int. <input type="checkbox"/> Out pt. <input type="checkbox"/> In pt. <input type="checkbox"/> Other	_____	_____
_____	<input type="checkbox"/> Crisis int. <input type="checkbox"/> Out pt. <input type="checkbox"/> In pt. <input type="checkbox"/> Other	_____	_____

Other information pertinent to previous behavioral health treatment:

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## **Members of the Youth's Household**

Name	Relation to Youth	Age	Name	Relation to Youth	Age

## **Reason for Referral:**

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## **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 his/her 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 his/her 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.

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## Youth Factors

- |  |  |
|--|--|
| <input type="checkbox"/> Runaway/leaving home without permission   | <input type="checkbox"/> History of inpatient psychiatric                            |
| <input type="checkbox"/> Withdrawal from family, social activities | <input type="checkbox"/> Hospitalization(s)  |
| <input type="checkbox"/> Recent dramatic changes in eating habits, | <input type="checkbox"/> Chronic Illness   |
| <input type="checkbox"/> Sleep pattern or body weight              | <input type="checkbox"/> Self-abusive behavior                                       |
| <input type="checkbox"/> Age or developmentally inappropriate      | <input type="checkbox"/> Repeated incidents of lying, stealing, property destruction |
| bed-wetting or soiling   | <input type="checkbox"/> Physical aggression toward authority figures or family      |
| <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  |

## Caregiver/Family Factors

- |  |   |
|--|---|
| <input type="checkbox"/> Chronic physical illness in family            | <input type="checkbox"/> Parental incarceration                       |
| <input type="checkbox"/> Family history of mental illness, psychiatric | <input type="checkbox"/> History of domestic violence                 |
| hospitalization or substance abuse                                     | <input type="checkbox"/> Poverty                                      |
| <input type="checkbox"/> Suicide attempts                              | <input type="checkbox"/> Other children in foster care                |
| <input type="checkbox"/> Victim of physical abuse (other than youth)   | <input type="checkbox"/> Youth exposed to substance abuse in the home |
| <input type="checkbox"/> Victim of sexual abuse (other than youth)     |   |

## Other Information

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

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

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