



NW C.A.R.E. REFERRAL PACKET

**NW C.A.R.E. Systems of Care
(Communities Accessing Resources for Everyone)
1111 2nd St. – P.O. Box 913
Woodward, OK 73801
Telephone (580) 254-5322
Fax (580) 254-5335**



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Enclosed 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 “wrap-around” care and 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.

The goals are twofold:

1st 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 between family members and others supportive of the family.

2nd we hope to assist the family in developing a strong support system that can be relied on after “Systems of Care” has moved on to provide support to new families.

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

After the follow-up, the referral will be taken to a community referral team at which time a determination will be made to either accept the child or assist the child and family in finding alternative services.

NW C.A.R.E. 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: _____ Grade: _____

Caregiver Name: _____ Relationship to Child: _____

Address: _____

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

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

Indicate if the youth is:

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

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

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

Receiving other services (specify): _____

On medications (please list): _____

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

Risk Factors *(please check all that apply)*

Youth Factors

Runaway / leaving home without permission

Chronic illness

Withdrawal from family, social activities

Self-abusive behavior

Recent dramatic changes in eating habits, sleep pattern or body weight

Repeated incidents of lying, stealing, property destruction

Age or developmentally inappropriate bed-wetting or soiling

Physical aggression toward authority figures, family members, peers

Inappropriate sexual behavior

Intentionally hurts others

Perpetrator of sexual abuse

Intentionally hurts animals

Victim of sexual abuse

Sets fires

Victim of physical abuse

Involvement in criminal activity

Use or abuse of alcohol or drugs

Declining school grades, truancy, poor attendance

Attempted suicide or suicidal thoughts

School suspensions / expulsions

Hallucinations – aural, visual or tactile

Developmental delays

History of inpatient psychiatric hospitalization(s)

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?

Why is this family being referred? _____

What services, if any, has the child received in the past? _____

Please add any other information that might be helpful _____

NW C.A.R.E.
Consent for the Release of Confidential Information

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

Hereby authorize NW C.A.R.E. to RELEASE to or to OBTAIN from Referral Team – NWCBH; Woodward Public Schools; NW Domestic Crisis; PAT; Woodward Co. Health Dept; DHS; OJA; Headstart; WPYFS

The following information:

<input type="checkbox"/> Initial Contact	<input checked="" type="checkbox"/> Verbal Communication	<input checked="" type="checkbox"/> Ed/Voc Assessments
<input checked="" type="checkbox"/> Physician's Orders	<input checked="" type="checkbox"/> Treatment Plans	<input checked="" type="checkbox"/> Termination Summary
<input checked="" type="checkbox"/> Psych-Soc Assessments	<input type="checkbox"/> Progress Notes	<input checked="" type="checkbox"/> History
<input type="checkbox"/> Appt. Rescheduling		

Information necessary to process billing/insurance claims (dates of service, charges, diagnosis, mode of therapy, or any other information as needed).

Other (specify): on-going evaluation for NW C.A.R.E.

For the following purpose: Coordinating Services

Date, event or condition of expiration:

30 days after case closed at NW C.A.R.E. 90 days from date of signing consent
 Upon receipt of information Other (specify): _____

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 you 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 regulation. I also understand that I may revoke this consent (in writing) at any time unless action has already been taken based upon it, and that my treatment services aren't contingent upon, or influenced by, my decision to permit the information release.

The information I authorize for release may include information that could be considered information about communicable or venereal diseases which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Deficiency Syndrome (AIDS).

Drug/Alcohol Abuse Records: Confidentiality of drug/alcohol abuse records is protected by Federal Regulations (42CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who 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/drug abuse patient.

I do not authorize further release to any other party. I understand that NW C.A.R.E. officers and directors cannot be responsible for confidentiality of information disclosed after said information had been released pursuant to this authorization, and I hereby release them from any liability arising from such disclosure.

Executed this _____ day of _____, _____

Signature of Client

Signature of NW C.A.R.E. Program Personnel

Witness

Signature of Parent, or Guardian