

**PAYNE COUNTY SYSTEMS OF CARE  
REFERRAL / INFORMATION PACKET**

**Return completed referral to:  
Edwin Fair CMHC  
Attn: Project Director  
800 E. 6<sup>TH</sup> SUITE B, STILLWATER, OK 74074,  
(405) 372-1250**

The Payne County Systems of Care Project is a comprehensive spectrum of services, which provides support to children and adolescents with mental, emotional and behavioral impairments and to their families. Services are child centered, family-focused and community based.

The following criteria are the guidelines for involvement:

- Have behavioral/emotional symptoms that suggest a diagnosable emotional disorder
- Be ages 4 through 20
- Living in Payne County and have a parent, guardian or foster parent living in Payne County
- Have a significant difficulty that has or is expected to last for a year or more due to his/her serious emotional and /or behavioral disturbance
- The child needs, has received, or has requested services/support from two or more support systems
- Be at risk of out of home or school placement due to the impact of the serious emotional and / or behavioral disturbance.

An Interdisciplinary Review Team will review the referral and make the determination of approval into the Payne County Systems of Care (see below for more information). Upon approval a Care Coordinator will contact the family.

**INSTRUCTIONS:**

The following four-page referral form and release must be read and filled out completely by the referral source and the parent/guardian. The diagnostic information is helpful if available. The parent/guardian's initials by the following bullets and signature on the accompanying release must be present for the referral to be considered by the Review Team.

- An Interdisciplinary Review Team, for approval into the Payne County Systems of Care, will review the following referral form. The Review Team consists of, but may not be limited to, representatives from the following agencies: Edwin Fair Community Mental Health Center, Department of Human Services, Office of Juvenile Affairs, Noble County Health Department, Payne County Youth Services, Area School Systems, NAMI Oklahoma, and Parent Representatives.

Parent/Guardian's Initials \_\_\_\_\_

- Upon Approval: If the referred child is approved for Systems of Care, an additional release will be obtained from the parent/guardian in order that the Review and Evaluation Team can monitor periodic review of the wraparound services.

Parent/Guardian's Initials \_\_\_\_\_

- If not Approved: If the referred child is not approved for Systems of Care, the family will be referred to other possible services and the release becomes null and void

Parent/Guardian's Initials \_\_\_\_\_

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**FOR OFFICE USE ONLY**

**ROUTING (Please provide information to each corresponding entry):**

- |   |   |
|---|---|
| 1. Date Referral Received _____           | 7. Date 1 <sup>st</sup> Strength Assessment _____ |
| 2. Date 1 <sup>st</sup> Contact _____     | 8. Date 1 <sup>st</sup> Team Meeting _____        |
| 3. Date Review Team Decision _____        | 9. Date 1 <sup>st</sup> Wraparound _____          |
| 4. Review Team Decision _____             | 10. Care Coordinator Assigned _____               |
| 5. Date Communicate Rev Tm Decision _____ | 11. Parent Advocate Assigned _____                |
| 6. Date Intake _____                      |   |

**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: \_\_\_\_\_

**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 reside 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**

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**Risk factors** (please check all that apply)

**Youth Factors**

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

**Caregiver / Family Factors**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_  CONSUMER  PARENT  GUARDIAN OF:  
(Consumer, parent or guardian must initial correct box)

\_\_\_\_\_  
(Name of Consumer) SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ - \_\_\_\_ - \_\_\_\_

## AUTHORIZE:

To release to: \_\_\_\_\_  
(Name of Person and/or Facility Making Referral To Review Team)

To receive from:

To receive and release:  
(Consumer must initial choice of boxes) \_\_\_\_\_  
(Street Address or P.O. Box, City, State, Zip Code)

## TO:

**The Payne Co. Systems of Care Interdisciplinary Review Team includes representatives from, but is not limited to, these agencies: Edwin Fair CMHC, Department of Human Services, Office of Juvenile Affairs, Payne County Health Dept., Youth Services, Area School Systems, NAMI Oklahoma, and Parent Representatives.**

My protected health information by:  Postal Service  Phone/Verbal  FAX  E-Mail  
(Consumer must initial choice of boxes)

Information to be disclosed: Payne County System of Care Referral Form  
(Specific description of information to be disclosed)

For the following purpose(s):  Approval for Participation in the Payne Co. Systems of Care  
(Release will be void if applicant is not accepted in the Program)  
 Continued Participation in the Payne Co. Systems of Care

This consent shall expire as follows: \_\_\_\_\_  
(Name the date, event or condition upon which consent expires)

I hereby acknowledge that this consent for the release of information is given freely and voluntarily. I understand that I may revoke this consent, in writing, at any time, by contacting my clinician. This consent expires in one (1) year from the date of signing or upon the conditions(s) described above. I understand that my records are protected under State and Federal confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in those laws and regulations. The information may not be protected from further disclosure by the recipient.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). [63-O.S.-1-502.2(B)]

Notice to individuals releasing alcohol and drug abuse treatment records: There shall be a statement in bold face, stamped upon each page of the information released stating, "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 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.

\_\_\_\_\_  
Signature of Consumer, Parent, Guardian or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Title of Person Releasing Information (Making Referral)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date