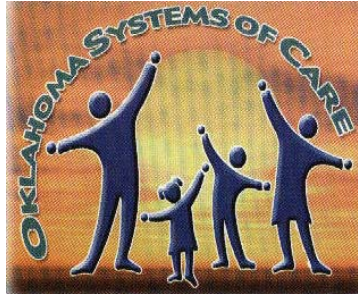


Pontotoc County Systems of Care



REFERRAL PACKET

Ada Area Youth Shelter Inc.
901 W 18th
Ada, Ok 74820
(580)436-6130

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 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 Pontotoc 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 Pontotoc County Systems of Care.

If you believe that Pontotoc 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. Pontotoc 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 Pontotoc 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: Crystal Smith, *Project Director*
Pontotoc County Systems of Care
901 W 18th Street
Ada, OK 74820
(580)436-6130 e-mail: crystalsoc@cableone.net

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, destruction of property |
| <input type="checkbox"/> Age or developmentally inappropriate bed-wetting or soiling | <input type="checkbox"/> Physical aggression toward authority, 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

Chronic physical illness in family

Family history of mental illness, psychiatric hospitalization or substance abuse

Suicide Attempts

Victim of physical abuse (other than youth)

Victim of sexual abuse (other than youth)

Parental Incarceration

History of domestic violence

Poverty

other children in foster care

Youth exposed to substance abuse

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?

**Pontotoc County Systems of Care
Release of Confidential Information**

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

Herby Authorize (Referring source)

To Release To:
Pontotoc County Systems of care
901 W 18th
Ada, OK 74820

The information indicated below for the purpose(s) (Client must initial):

- | | | |
|--|---|--|
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Health & Medication History | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Psychosocial Assessment | <input type="checkbox"/> Alcohol / Drug Information | <input checked="" type="checkbox"/> SOC Referral |

Period of Time Covered By Information to Be Released: _____

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 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 parts 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 venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, tuberculosis, and the human immunodeficiency virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I understand 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 Pontotoc County Systems of Care from making any further disclosure of it with out the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. I also understand that I may revoke this consent (in writing) at any time unless action has already been taken. This consent will expire upon termination of services or six months from _____.

By signing below I indicate that my consent to the release of this information is given freely and voluntarily.

Client Signature

Date

Signature of parent, guardian,

Date

Representative (relation to client _____)

