

REFERRAL/INFORMATION PACKET

Washington County System of Care

Return completed referral to:
Youth and Family Services of Washington County
ATTN: Project Director
2200 SE Washington Blvd. Bartlesville, OK 74006
Phone: 918/335-1111 Fax: 918/335-1119

Washington County System of Care is a comprehensive spectrum of services, which provides support to meet the multiple and changing needs of children and adolescents with a mental, emotional, or behavioral disturbance and to their families. These “wraparound” services are youth-centered, family-focused, and community based.

The following criteria are the guidelines for involvement for youth ages 5 to 17.5:

- The youth has behavioral/emotional symptoms that suggest a diagnosable emotional disorder.
- The youth is having significant difficulty that has lasted or is expected to last for a year or more due to her/his serious emotional and/or behavioral 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 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 Washington County.
- The family volunteers for this service and agrees to actively participate, if approved.

The criteria for youth ages 0 to 5 are on the following page.

The Referral Team (an interdisciplinary review team) will review this referral and make the determinations of approval into the Wraparound Process of Washington County System of Care (see below for more information). The family and referral source will be notified of the Referral Team’s decision.

INSTRUCTIONS:

The referral source should complete the four-page referral form and release form—it is important to have the parent sign the release form to allow wraparound staff to discuss this referral with the referral source. The criteria page for youth ages 0 to 5 only needs to be completed if a youth in that age range is being referred. Any 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 reviewed by the Referral Team. Upon receiving a referral, the family and the referral source will be contacted by wraparound staff.

- The Referral Team reviews all referrals. The Referral Team consists of, but may not be limited to, representatives from the following agencies: Grand Lake Mental Health Center, Department of Human Services, Office of Juvenile Affairs, Youth and Family Services of Washington County, Bartlesville Public Schools, Westside Community Center, and Parent Representatives.
Parent/Guardian Initials: _____
- **Upon Approval:** If the referred youth is approved to begin the Wraparound Process of Washington County System of Care, an additional release will be obtained from the parent/guardian in order for the Referral Team to monitor periodic review of the wraparound process.
Parent/Guardian Initials: _____
- **If Not Approved:** If the referred youth is not approved for the Wraparound Process of Washington County System of Care, the family will be referred to other possible services and the accompanying release becomes null and void.
Parent/Guardian Initials: _____

FOR OFFICE USE ONLY

- | | |
|--|---|
| 1. Date Referral Received: _____ | 4. Referral Team Decision: _____ |
| 2. Date of first contact: _____ | 5. Date family notified of decision: _____ |
| 3. Date of Referral Team Decision: _____ | 6. Date referral source notified of decision: _____ |

Washington County System of Care Referral Criteria for Birth to Five

- The child has behavioral/emotional symptoms that suggest a diagnosable emotional disorder according to the DSM IV or the DC:0-3R
- or**
- The parent(s) has behavioral/emotional symptoms that suggest a diagnosable emotional disorder
- or**
- The parent(s) needs, has received or has requested services or support from two or more systems
- or**
- Obtain a score of 60 or more on the Healthy Families & Babies Family Assessment Tool
- or**
- The parent(s) exhibit four or more of the following risk factors:

Circle area that applies and ✓ check box to whom it applies:

1. Parental Status: Teen; Single; Divorced; Widowed; Separated
2. Prenatal Care: Late; Poor Compliance; None
3. Considered Abortion/Adoption: During Pregnancy or Labor
4. History of Abortion/Adoption of Other Children
5. Infant Status: Premature; Small; Medically Fragile
6. Drugs or Alcohol: History of Use; Used During Pregnancy
7. Education: Under 12 Years; (GED counts as 12)
8. Mental State: Psychiatric Disorder; Retardation; Cognitively Impaired; History of Depression; Currently Depressed
9. Unstable Living Situation: Move Frequently; No Phone
10. Financial Situation: Low Income; Unemployed; TANF; WIC; Medicaid
11. No Emergency Contacts; Lack of Support System; Relatives Distant
12. Marital or Family Problems: Abusive Relationship; Constant Conflict
13. Abuse/Neglect: Parents have a history of abuse/neglect with other children; CPS involvement (year) _____
14. Parents were abused or neglected during childhood
15. Parental Loss Prior to age 5

	Mom	Dad	Does Not Apply	Unknown by Staff
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

WASHINGTON COUNTY SYSTEM OF CARE

2200 S.E. Washington Blvd., Bartlesville, OK, 74006

Phone: (918) 335-1111 - FAX: (918) 335-1119

Referral Form

Referring Agency: _____ Date of Referral: _____

Referring Person: _____ Phone: _____

Original referral source, if different from above: _____

Youth Information:

Name: _____ Date of Birth: _____ Age: _____

Race/Ethnicity: _____ Sex: _____ SS#: _____

School: _____ Grade: _____ School Phone: _____

Caregiver Name: _____ Relationship to youth: _____

Address: _____

City: _____ County: WASHINGTON State: .OK. 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 treatment: Agency: _____ Phone: _____

In mental health treatment: Agency: _____ Phone: _____

Receiving other services (specify): _____

On medications (please list): _____

Risk Factors (please check all that apply):

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

Other information:

How can this youth and her/his family benefit from their environment 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? _____

Washington County Systems of Care
2200 S.E. Washington Blvd., Bartlesville, OK, 74006
Phone: (918) 335-1111 - FAX: (918) 335-1119

Authorization for Release of Confidential Information

Client:	DOB:	SS#:
Address:	City:	State: Oklahoma Zip:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal Privacy regulations.

I understand that the records requested may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164, State Confidentiality laws and regulations and cannot be released without my consent unless otherwise provided for by regulations. State and Federal laws and regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulation.

Clients in Criminal Justice System: Any disclosure made is bound by the federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 U.S.C., 290dd-2; 42 C.F.R. Part 2) and that recipients of the information may receive and re-disclose it only in connection with their official duties with respect to the particular criminal proceedings and may not be used in other proceedings, for other purposes, or with respect to other individuals.

Persons/Organizations **providing** the information:
Referral Source: _____

Persons/organizations **requesting/receiving** the information:
Washington County Systems of Care—Wraparound _____
Address: 2200 SE Washington Blvd. _____
Bartlesville, OK 74006 _____

Purpose of use or disclosure: Referral to Wraparound services & exchange information to determine appropriateness for services.
Specific description of information including dates: _____

Method of Release: Fax _____ Mail _____ Verbal Exchange _____ Other _____

The client or the client's representative must read and **initial** the following statements:

1. I understand that this authorization will expire on ___/___/___ (MM/DD/YY) or discharged (not to exceed one year from the date of signature below.) (event) Initials _____
2. I understand that I may revoke this authorization as described in the Notice of Privacy Practices at any time by notifying the providing organization's Privacy Officer in writing, but if I do it won't have any affect on any actions they took in reliance on my authorization before they received the revocation. Initials _____
3. I understand that generally Washington County Systems of Care may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. Initials _____

FURTHER, THE ABOVE PROTECTED HEALTH INFORMATION (PHI) 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). I FURTHER UNDERSTAND THAT MY PHI MAY INDICATE THAT I HAVE BEEN TREATED FOR PSYCHOLOGICAL, PSYCHIATRIC OR SUBSTANCE ABUSE CONDITIONS.

_____/_____ Signature of client or client's representative/guardian	Date	_____/_____ Witness	Date
--	------	------------------------	------

(Form must be completed before signing.)

Printed name of client's representative: _____
Relationship to the client/authority to act for client: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Original – with copies Copy – client Copy – WCSOC record Draft 4/05
--

Release to Client or Guardian: Practitioner Name _____ Approval Date _____
--

