

**REFERRAL/INFORMATION PACKET**

**Tri-County Wrap-Around**

Return completed referral to:

**Tri-County Wrap-Around**

ATTN: Project Director – Jeff Harlin

120 South Treaty Road Miami, Ok. 74354

Phone: (918) 540-1511 ext. 2367

Fax: (918) 542-7374

Tri-County Wrap-Around is a comprehensive spectrum of services, which provides support to meet the multiple and changing needs of children and adolescents with mental health, emotional, and / or behavioral difficulties, and to assist their families. These “wraparound” services are youth-centered, family-focused, and community based.

The following criteria are the guidelines for involvement of children / adolescents ages 4 to 17:

- 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 Ottawa, Craig, and Delaware Counties.
- The family volunteers for this service and agrees to actively participate, if approved.

The Referral Team (an interdisciplinary review team) will review this referral and make the determinations of approval into the Process of Tri-County Wrap-Around (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. 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 may consist of but not limited to, representatives from the following agencies: Grand Lake Mental Health Center, Department of Human Services, Office of Juvenile Affairs, Public Schools, and Parent Representatives.  
Parent/Guardian Initials: \_\_\_\_\_
- **Upon Approval:** If the referred youth is approved to begin the Process of Tri-County Wrap-Around, 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, the family will be referred to other possible services and the accompanying release becomes null and void.  
Parent/Guardian Initials: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

- 1. Date Referral Received: \_\_\_\_\_
- 2. Date of first contact: \_\_\_\_\_
- 3. Date of Referral Team Decision: \_\_\_\_\_

- 4. Referral Team Decision: \_\_\_\_\_
- 5. Date family notified of decision: \_\_\_\_\_
- 6. Date referral source notified of decision: \_\_\_\_\_

# TRI-COUNTY WRAP-AROUND

120 South Treaty Road – Miami, Ok. 74354  
Phone: (918) 540-1511 ext. 2367 - FAX: (918) 542-7374  
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: \_\_\_\_\_ State: .OK. Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Indicate if the youth is:

DHS:  Involved  In custody DHS worker/phone: \_\_\_\_\_  
Name Number

OJA:  Involved  In custody OJA worker/phone: \_\_\_\_\_  
Name Number

In substance abuse treatment:  Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

In mental health treatment:  Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

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

On medications (please list all medications including names, dosages, effectiveness, and any side-effects): \_\_\_\_\_

## Initial Screening - Please check all that apply:

- The youth has behavioral/emotional symptoms that suggest a diagnosable emotional disorder.
- The youth has 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 Ottawa, Craig, or Delaware County.
- The family volunteers for this service and agrees to actively participate.

**General mental health /diagnostic comments (fill in any information that is available):**

\_\_\_\_\_

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

Name	Relation to Youth	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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 his/her family benefit from their involvement with Tri-County Wrap-Around?

\_\_\_\_\_

What other information about the youth and his/her family do you feel would be helpful to Tri-County Wrap-Around staff?

\_\_\_\_\_

# Tri-County Wraparound

120 S. Treaty Road – Miami, Ok. 74354  
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## 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: \_\_\_\_\_

Persons/organizations **requesting/receiving** the information:

Tri-County Wrap Around / GLMHC

Address: 120 S Treaty Rd

Miami Ok 74354

Purpose of use or disclosure: \_\_\_\_\_

Specific description of information including **dates:** \_\_\_\_\_

Method of Release: Fax \_\_\_\_\_ Mail \_\_\_\_\_ Verbal Exchange \_\_\_\_\_ Other \_\_\_\_\_

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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 Until Discharge (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

\_\_\_\_\_/\_\_\_\_\_  
Signature of client or client's representative/guardian 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 – TCSOC record

Release to Client or Guardian:  
Practitioner Name \_\_\_\_\_  
Approval Date \_\_\_\_\_

