SCO Family of Services

Extraordinary reach.
Unconditional care.
Life-changing results

Revised 1/25/2022

Children and Family Treatment and Support Services Referral Form

T: 718-312-6829

Please submit all completed forms to homebasedsupports@sco.org

Date of Referral		☐ **Internal SCO Referral**	☐ **External Referral**	
Provider Making Referral	**First Name**		**Last Name**	
	Agency Name		**Title**	
	Phone #		**Email**	
	Address			
Consenter Information	**Consenter Name**		**Phone #**	
	Relationship to Youth		**Preferred Time/ Method of contact?**	
	Consenter Address			
Case Planning Information *If applicable	**Case Planning Agency**		**Case Planner Name**	
	Case Planner Email		**Case Planner Phone #**	
Health Home Care Coordinator Information *if applicable	**First Name**		**Last Name**	
	Agency Name		**Phone #**	
	Address		**Email**	
Participant Information	**First Name**		**Last Name**	
	Gender	☐ **Male** ☐ **Female**	**Date of Birth**	
	Ethnicity		**Race**	
	Caregiver		**Primary Language**	
	Caregiver Relationship		**Foster Care Status**	☐ **In Care** ☐ **Out of Care**
	Phone #		**Alternate Phone #**	
	Email			
	Address			

Treatment Information	**Current Treatment Services:**	If youth is involved in mental health and substance use disorder treatment services, please list 1. Type of Service, 2. Reason 3. Name of Agency Rendering Service, 4. Provider Contact Information:
Participant Health Care Information	**Managed Care Organization (MCO):**	**Medicaid CIN Number:**
	Please list all known prescribed medications (Name, Dosage, Regimen):	

Symptoms of Concern *Check all that apply			
Depression ☐	Anxiety ☐	Phobia ☐	Impulsive ☐
Temper Tantrums ☐	Sleep ☐	Enuresis/Encopresis ☐	Danger to Others ☐
Developmental Delays ☐	Sexually Inappropriate ☐	Sexually Aggressive ☐	Alcohol Use ☐
Physically Aggressive ☐	Eating Disturbances ☐	Hyperactivity ☐	Drug Use ☐
Self-Injury ☐	Delinquent Behavior ☐	Problematic Social Behavior ☐	Runaway ☐
Negative Peer Interactions ☐	Attention Deficits ☐	Danger to Self ☐	Sleep Issues ☐
Physical Aggression ☐	Verbal Aggression ☐		

Any Known Safety Concerns? *(Criminal Record, History of Violence, Weapons in the Home, Sex Offender, General Concerns, etc.):*

Why is the youth being referred for services?

Any Identified Service Restrictions Surround Client Availability and or known days they are available:

Client and Family Strengths:

Are there any known health concerns?

Does the youth being referred reside with another youth(s) who are receiving CFTSS Services from SCO? If yes, please provide youth(s) name(s) to better ensure consistency/familiarity among staff:				
Referred CFTSS Services(S) **Note: Only complete sections that are white, gray shading indicates components of the service**				
Service Requested	**Individual Vs. Group**		**Is the family/client open to Telehealth for this Service:**	
Other Licensed Practitioner (OLP)	☐ **Individual**	☐ **Group**	☐ **Yes**	☐ **No**
❖ OLP Licensed Evaluation				
❖ OLP Counseling				
❖ OLP Crisis				
❖ OLP Crisis Triage				
Psychosocial Rehabilitation (PSR)	☐ **Individual**	☐ **Group**	☐ **Yes**	☐ **No**
Community Psychiatric Treatment and Supports (CPST)	☐ **Individual**	☐ **Group**	☐ **Yes**	☐ **No**
❖ Intensive Interventions				
❖ Crisis Avoidance				
❖ Intermediate Term Crisis Management				
❖ Rehabilitative Psycho-education				
❖ Strength-Based Service Planning				
❖ Rehabilitative Supports				
Family Peer Support Services (FPSS)	☐ **Individual**	☐ **Group**	☐ **Yes**	☐ **No**
Youth Peer Support Training (YPST)	☐ **Individual**	☐ **Group**	☐ **Yes**	☐ **No**
Worker Requirements				
Language Preference: **(If other than English)**	**Worker Gender Preference:**		**Is the family comfortable with more than one worker?**	

For Referring Individuals, Please Attach the Following:

- Medicaid Card (If Available)
- Evaluations (e.g., Psychological, Psychosocial, Psychiatric, IEP, Etc.)
- Other Pertinent Family Information