Children and Family Treatment and Support Services Referral Form

T: 718-312-6829

Please submit all completed forms to homebasedsupports@sco.org

Note: Only complete sections that are white, gray shading indicates description of information needed.

Date of Referral		☐**Internal SCO Referral** ☐**External Referral**	

Section	Field		Field	
Provider Making Referral	**First Name**		**Last Name**	
	Agency Name		**Title & Program**	
	Phone #		**Email**	
	Address			
Medical Consenter's Information	**Name** *(First & Last)*		**Phone #**	
	Relationship to Youth	☐ Parent ☐ Guardian ☐ Legally Authorized Representative ☐ Youth (18 and older)	**Email**	
	Consenter's Address		**Preferred Time & Method of contact?**	
Case Planning Information *If applicable	**Case Planning Agency**		**Case Planner's Name**	
	Case Planner's Email		**Case Planner's Phone #**	
	Agency Address			
Health Home Care Coordinator Information *if applicable	**Agency Name**		**Care Manager's Name**	
	Care Manager's Email		**Care Manager's Phone #**	
	Agency Address			

If NOT currently enrolled in Health Home Care Management would the family like to be referred?
☐ **Youth Only** ☐ **Parent Only** ☐ **Both Youth & Parent** ☐ **Neither**

Section	Field		Field	
Youth Being Referred	**First Name**		**Last Name**	
	Preferred Name		**Pronouns**	
	Gender	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender female ☐ Non-Binary ☐ Other	**Date of Birth**	
	Ethnicity & Race		**Primary Language**	
	School Name		**Current Grade**	
	Caregiver's Name		**Caregiver's Primary Language**	
	Caregiver Relationship		**Foster Care Status**	☐In Care ☐Out of Care
	Phone #		**Alternate Phone #**	
	Email			

	Caregiver's/Youth Address				
Current Treatment Services	**Mental Health Services**	**Is youth actively engaged in mental health counseling? ☐ Yes ☐ No** **Is youth actively engaged in substance use counseling? ☐ Yes ☐ No** ** If youth is involved in mental health and/or substance use disorder treatment services, please provide information below:*			
	Therapist/Counselor		**Provider Agency**		
	Contact Information Phone/Email				
	Other Provider		**Provider Agency**		
	Contact Information Phone/Email				
Diagnoses	**Mental Health Diagnoses (If any)** *DSM-5 and/or ICD-10				
	Physical Diagnoses (If any)				
	Diagnosed By (Physician's Name MH or PH)		**Diagnoses date (Within past year)**		
Health Care Information	**Managed Care Organization (MCO):**		**Medicaid CIN Number:**		
	Please list all known prescribed medications (Name, Dosage, Regimen):				

Symptoms of Concern *** Check all symptoms that have impacted the youth over the past 60 days**			
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 ☐	Substance Use ☐
Self-Injury ☐	Delinquent Behavior ☐	Problematic Social Behavior ☐	Runaway ☐
Negative Peer Interactions ☐	Attention Deficits ☐	Danger to Self ☐	Sleep Issues ☐
Physical Aggression ☐	Verbal Aggression ☐	Other ☐ (Please Describe)	

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 Surrounding Client Availability and/or known days they are available:

Client and Family Strengths:

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 Service(s) **Note: Only complete sections that are white, gray shading indicates components of the service**		
Service Requested	**Individual and/or Group**	**Is the family/client open to Telehealth for this Service:**
Other Licensed Practitioner (OLP)	☐ **Individual** ☐ **Group**	☐ **Yes** ☐ **No**
❖ OLP Licensed Evaluation	☐ ***Requesting Evaluation Only ****	
❖ OLP Counseling		
❖ OLP Crisis		
❖ OLP Crisis Triage		
Psychosocial Rehabilitation (PSR)	☐ **Individual** ☐ **Group**	☐ **Yes** ☐ **No**
Community Psychiatric Supports and Treatment (CPST)	☐ **Individual** ☐ **Group**	☐ **Yes** ☐ **No**
❖ Intensive Interventions		
❖ Crisis Avoidance		
❖ Intermediate Term Crisis Management		
❖ Rehabilitative Psychoeducation		
❖ 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