Referral Packet

To: Persons/Agencies initiating placement of a child into the Therapeutic Crisis Respite Program (TCRP).

Fax: 315-201-8042
Phone: 315-777-9642
Cell: 315-955-9062
Email: tcrp@chjc.org

From: Intake Department

The following information will be required upon admission and will be reviewed and collected by the Program Manager:

- ☐ Signed Releases (signed by the parent/legal guardian)
- ☐ Disability Slip (if applicable)
- ☐ 15 Day Supply for all Medications (or 15 Day Prescription)
- ☐ Recent Psychological/Psychiatric Evaluation (if applicable)
- ☐ Recent Safety Plans (if applicable)
- ☐ Recent Discharge Summary (if applicable)

Thank you for your cooperation.

ADMISSION/REFERRAL EVALUATION FORM

DATE OF REFERRAL: **DATE OF ADMISSION:**

REFERRAL CONTACT INFORMATION

NAME: ORGANIZATION: ☐N/A

NUMBER:

EMAIL:

BEST TIME TO CONTACT:

RELATIONSHIP TO YOUTH:

DISCHARGE RESOURCE AND PLAN:

Demographic Information

CHILD'S NAME: (Last) (First) (M)

Nickname/Preferred Name:

AGE: DATE OF BIRTH: GENDER: RACE:

SOCIAL SECURITY #: __ __ __ / __ __ / __ __ __ __

ADDRESS:

COUNTY:

Parent/Caretaker/Guardian Information

PRIMARY CARETAKER:

RELATIONSHIP TO YOUTH:

CONTACT INFORMATION:

Number:

Email:

Address: ☐ Same as youth

New York,

Best time to Contact:

ALTERNATIVE/SECONDARY CARETAKER (if applicable):

RELATIONSHIP TO YOUTH:

CONTACT INFORMATION:

Number:

Email:

Address: ☐ Same as youth

New York,

Best time to Contact:

Presenting Problems/Concerns

Why are your seeking TCR services:

HAS CHILD DISPLAYED ANY OF THE FOLLOWING BEHAVIORS IN THE LAST SIX MONTHS:

☐ Assault ☐ AWOL ☐ Drug/Acohol Use ☐ Trauma ☐ Theft
☐ Suicide Attempt ☐ Fire Setting ☐ Aggression ☐ Brain Injury ☐ Sexual Offense
☐ Indiscriminate Sexualized Behaviors ☐ Cruelty Toward Animals ☐ Development Disability
☐ History of Out of Home Placement ☐ Other:

Please elaborate:

LIST ALL PREVIOUS HOSPITALIZATIONS:

Insurance Information

Medicaid: Yes ____ No ____ Medicaid # __ __ __ __ __ __ __ __

Other Insurance Company:

Policy Number: Policy Holder Name:

Note: Please provide a copy of the the insurance card is possible.

Medical Information

PRIMARY CARE PROVIDER: PHONE:
ALLERGIES: ADDICTIONS:
ACTIVE MEDICAL CONDITIONS:
CURRENT DENTAL OR EYE CONCERNS:

CURRENT MEDICATIONS:

NAME	DOSAGE	FREQUENCY	START DATE

****(Must have a 15 day supply or 15 day prescription)**

Psychiatric Information

THERAPIST: PHONE:

PSYCHIATRIST: PHONE:

PSYCHIATRIC DIAGNOSIS (list all):

CURRENT TREATMENT PROGRAMS:

DATE OF LAST EVALUATION:_____

PREVIOUS SUCCESSFUL SERVICES: _____
_____
_____

Current Service Providers (if applicable)

NAME	AGENCY	ADDRESS	TELEPHONE NUMBER	START DATE

Legal Information

Current Orders of Protection: ☐ Yes ☐ No ☐ Unknown
Is anyone not allowed to have contact with youth (include name if yes):
Legal Status (if applicable): ☐ JD ☐ PINS ☐ Article 10 ☐ Other ☐ Unknown ☐ Other:

Educational Information

CURRENT/LAST SCHOOL ATTENDED:

ADDRESS OF SCHOOL:

IS YOUTH ENGAGED IN BEFORE/AFTER SCHOOL PROGRAMS (IF YES, PROVIDE PROGRAM NAME AND DROP-OFF/PICK-UP TIMES):

SCHOOL HOURS- DROP-OFF:
PICK-UP:

CONTACT PERSON: GRADE LEVEL:

IEP: ☐ YES ☐ NO CLASSIFICATION:

I.Q: ☐ Unknown

If possible, please provide a copy of any academic testing results. When possible, CHJC will work with current school district to ensure continuity of education for the youth.

AUTHORIZATION AND CONSENT

Used for the coordination of services with regards to the referral for TCRP services.

Name of Child:_____ **DOB:**_____

PARTICIPATION:

Participation in the Therapeutic Crisis Respite Program (TCRP) is voluntary and available to all residents located in Jefferson, Lewis, and St. Lawrence counties. I also understand that this program evaluates and assists with the connection to long term services as it is not a substitute for long term treatment.

Immediate Authorization for Release for Information:

Our program follows all guidelines and regulations in regards to maintaining the confidentiality of your clinical records, which shall be maintained in accordance with the applicable State and Federal laws and regulations. Regulations but are not limited to section 33.13 of the Mental Hygiene Law, Article 27-F of the Public Health Law, the Health Insurance Portability and Accountability Act (HIPPA), 42 CFR Part 2 and New York State Office of Family & Children Services Mandated Reporter guidelines.

I understand that my child is being referred to TCRP for supportive services. As part of this referral, I grant my authorization and consent for the Therapeutic Crisis Respite Program to speak with the referring provider (identified on the referral form). I also understand that, as part of my child's referral to TCRP, the internal team regularly discusses service engagement and participate in treatment team meetings. These meetings are a collaboration between members of TCRP, Care Coordination of NNY, and the Community Clinic of Jefferson County, which are all affiliates of the Children's Home of Jefferson County (CHJC).

Authorization:

As part of my child's referral to TCRP, I grant my authorization for all the entities covered under the Children's Home of Jefferson County listed above to discuss this referral and collectively collaborate care for my child with: the referring party, and among the respective CHJC programs. This authorization continues for as long as my child is enrolled in any program affiliated with CHJC. I understand that I may cancel this authorization at any time.

Client Name	***Client Signature***	***Date***
Parent or Guardian Name	***Parent or Guardian Signature***	***Date***
Witness Name	***Witness Signature***	***Date***