### **CME Intensive Customized Care Coordination** Date of Referral:

**Please return completed form and any supporting documentation of diagnosis to: FamilyWrap@VPHealth.org**

**We will review your referral and contact you within three business days to discuss. We look forward to working with you!**

### Youth’s Last Name:       Youth’s First Name:       DOB:       Age:     Gender:       Gender Identity:

### Prefer not to disclose: [ ]  Race:       Primary Language       Secondary Language:

Parent/Guardian’s Name:       Relationship to youth:       County:

Home/Placement Address:            City:       Zip:

Family Phone #:       Another #       Email Address:

Additional Contacts: Name:       Relationship:       Phone:       Email Address:

Primary Insurance Carrier:       Primary Insurance Number:       Medicaid # (if applicable):      \_ Secondary Insurance Carrier:      Secondary Insurance Number:

Youth in DFCS Custody yes [ ]  no [ ]  Name of DFCS CM Contact Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_

**Referring Party Information****:** Name:      Email:       Phone:

|  |  |  |
| --- | --- | --- |
|  [ ] Parent/Guardian  [ ] Inpatient Hospital [ ] Residential Facility (PRTF) [ ] DJJ In Community [ ] DJJ Secure Facility |  [ ] DBHDD Core Provider [ ] Private Provider or Pediatrician [ ] Juvenile Court [ ] DFCS Family Preservation [ ] DFCS Custody (GA Families 360) |  [ ] System of Care (LIPT/CHINS/CSEC)  [ ] School System [ ] Crisis Stabilization Unit (CSU) [ ] Family Support Organization [ ] Other:  |

**Other Agencies Currently Involved:**

|  |  |  |
| --- | --- | --- |
|  [ ] Enrolled in School (check if YES) [ ] Inpatient Hospital  [ ] PRTF (Residential Facility) [ ] Child Caring Inst. (Group Home) [ ] Dept. of Juvenile Justice  |  [ ] DBHDD Core Provider [ ] Private Provider or Pediatrician [ ] Juvenile Court  [ ] DFCS (non-custody only) [ ] DFCS Custody (GA Families 360) |  [ ] Family Support Organization  [ ] Law Enforcement  [ ] Crisis Stabilization Unit [ ] Georgia Cares (CSEC) [ ] Other:  |

School Attending:       School Grade:       Special School Services:       [ ]  IEP [ ]  504 Plan

Mental Health Diagnoses:      Substance Use Diagnosis:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Developmental / IDD Diagnosis and Level:

Current Medication(s):       Do you have a GA CANS you are able to share with us? [ ]  Yes [ ]  No

Mental Health Provider Name:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number:      \_\_\_\_\_\_\_\_\_

Please provide a brief youth and family history:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe challenges the youth is having: (i.e. at home, in school and in the community):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the current Stressors in the home environment?      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Response to current treatments:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Problems/Risk:** Please select all applicable emergent and crisis needs:

[ ]  Self-harm [ ]  Suicidal thoughts [ ]  Suicide attempt [ ]  Threats of Violence [ ]  Homicidal thoughts or behaviors

[ ]  Runaway [ ]  Sexual Aggression [ ]  Delinquent Behavior [ ]  Intentional Behaviors [ ]  Property Destruction/Fire Setting

[ ]  Active Substance Use [ ]  Runaway [ ]  Imminent Risk of Out-of-Home Placement [ ]  Other:

**Please provide details for any Presenting Problems listed above occurring within the last 180 days (six months)**:

**Child Emotional/Behavioral Needs:** [ ]  Psychosis [ ]  Attention/Concentration [ ]  Impulsivity [ ]  Depression [ ]  Anxiety

[ ] Substance Abuse [ ]  Attachment Difficulties [ ]  Anger Control [ ]  PTSD [ ]  Phobia [ ] Obsessions/Compulsion

[ ]  Oppositional [ ]  Conduct [ ]  Adjustment to Trauma [ ] Other:

**Past or current exposure to Potentially Traumatic / Adverse Childhood Experiences:**

[ ]  Sexual Abuse [ ]  Physical Abuse [ ]  Emotional Abuse [ ]  Neglect [ ]  Witness to Family Violence [ ]  Community Violence [ ]  School Violence [ ]  Parental Criminal Behavior [ ]  Disruptions in Caregiving/Attachment Losses [ ]  Other:

**Life Functioning Needs:**

[ ]  Family [ ]  Living Situation [ ]  Social Functioning [ ]  Legal [ ]  Sleep [ ]  Recreational [ ]  School Behavior [ ]  School Attendance [ ] Decision Making [ ] School Achievement [ ]  Recreational [ ] Developmental [ ] Recreational [ ]  Job Functioning [ ] Legal [ ]  Medical/Physical [ ] Sexual Development

**Please select any of the following services the youth has received in the past 6 months:**

|  |  |  |
| --- | --- | --- |
|  [ ] Inpatient Hospital  # of Inpatient Admissions [ ]  [ ] Residential Treatment Facility # of PRTF Admissions       |  [ ] DJJ [ ] DFCS / CCI / CPA [ ] Juvenile Court [ ] RYDC # of Stays       |  [ ] Youth Development Center  [ ] Crisis Stabilization Unit # of CSU Admissions     [ ] Other:       |

Has youth/family been presented at LIPT or CHINS? [ ] Yes [ ] No If yes, team recommendation:

Has the family been informed about services provided by View Point Health and provided consent for the referral? [ ]  Yes [ ] No

Are the parents /Guardian accepting of support from Wraparound? [ ]  Yes [ ]  No

If youth is 18 years and older does youth accept support from wraparound? [ ]  Yes [ ]  No

***NOTE*: Please attach the following information if available: Verification of diagnosis, Behavioral Health Assessment, CSU/PRTF Discharge Papers, GA CANS, Dr. Appointment Notes, and a Copy of Insurance Cards**

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