### **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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