

Coordinated Services Team (CST)

Referral Form

Name of child (include middle initial): _____

Date of Birth: _____ Age: _____ SSN: _____

Funding source (circle): MA, SSI, Katie Beckett, Private Insurance, Parents,
Other (please describe) _____

Please check all that apply:

____ Use of multiple direct services (e.g. mental health, special education, juvenile justice, child protective services, alcohol or other drug services)

____ Other interventions have not been successful over time, or persistent obstacles to service access and/or need for service coordination exists

____ At risk of out of home/institutional placement

____ Parents are willing to be involved in the team process

Child's Address: _____

Phone Number: _____

Living With: _____ Relationship: _____

List other significant people in the home (please include age and relationship): _____

List other significant people not in the home (please include age and relationship): _____

Complete the following information if different from above:

Parent(s) Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Referral Person: _____ Referral Date: _____

Phone Number: _____

Reason for Referral: _____

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Service Provider Information

Does the child have a Mental Health diagnosis?

If **yes**, please complete the remainder of the referral form, including the *Severe Emotional Disturbance (SED) Checklist* (Appendix A).

If **no**, please complete the remainder of the referral form, and disregard the *Severe Emotional Disturbance (SED) Checklist* (Appendix A).

Mental Health Provider: _____

Contact Person: _____ **Phone Number:** _____

Describe Involvement: _____

Is the child involved with the Juvenile Justice system, Child Protective Services (CPS), or Alcohol/Other Drug Abuse (AODA) services?

If **yes**, please complete the provider information below and *attach documentation* of services (can obtain through the family's social worker).

If **no**, please continue with "Educational Provider" information.

Juvenile Justice, CPS, or AODA Service Provider: _____

Contact Person: _____ **Phone Number:** _____

Describe Involvement: _____

Educational Provider: _____ **Special Education?** Yes No

Contact Person: _____ **Phone Number:** _____

Describe Involvement: _____

Other Agency/Provider: _____ **Phone Number:** _____

Contact Person: _____

Describe Involvement: _____

Consent for Referral and Participation

I give my consent to _____ to refer my child and family members as identified to the _____ Coordinated Services Team (CST) initiative. I agree to participate in the team process and to play an active role in the assessment and case planning processes.

I understand that I will be asked to identify the service providers working with my family and to sign release forms authorizing the exchange of information. I realize that as long as our family is involved in CST, it will be necessary for service providers to routinely review and share information.

Signature of Individual Authorizing Referral

Date _____

Second Authorization/Witness Signature

Date _____

Coordinated Services Team

CONFIDENTIAL INTERAGENCY INFORMATION RELEASE AUTHORIZATION

Name: _____ Birthdate: _____
Address: _____ Phone: _____

All agencies/individuals listed below are hereby authorized to release and obtain information from all of the other agencies/individuals listed below:

Agency/Individual: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

Agency/Individual: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

Agency/Individual: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

Agency/Individual: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

Agency/Individual: _____
Address: _____
City, State, Zip: _____
Phone #: _____
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Agency/Individual: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

Agency/Individual: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax #: _____

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I, _____ hereby authorize all of the named individuals/agencies listed on page 1 of this document to release and/or obtain from any other of the above named individuals/agencies the following written and/or verbal information/records, unless otherwise specified: mental health assessment and/or treatment; psychiatric evaluation and/or treatment; psychological testing; medical and physical examinations and/or treatment; alcohol and other drug abuse assessment and/or treatment; developmental disabilities assessment and/or case management; Human/Social Service and/or Court records; educational testing, and school records, Other _____.

The purpose or need for the information requested is () Assessment and/or Treatment; () Case Management Services; () Interagency Coordination, Other _____.

REDISCLASURE NOTICE: The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting (insert your agencies name and contact information here). **Right to Receive Copy of this Authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** – I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/ or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. (Exception: To provide care that is done solely for the purpose of creating information to release to another party, in which case care cannot be provided without authorizing disclosure. Authorization is needed to release information to payers for certain mental health services and HIV testing. If I refuse to sign the authorization form for this purpose, I understand I may be responsible for paying the entire bill for these services.) **Right to Revoke This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the (insert your agencies name and contact information here). I am aware that my withdrawal will not be effective as to uses and/or disclosure of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration date: This authorization is good until one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ **Date** _____

Signature of Above Named Child (Required for release of AODA information if 14 years old or over)

_____ **Date** _____

Signature of Individual Authorizing Release (If signed by other than client state relationship & authority to do so)

() Parent () Guardian () POA for HealthCare () Spouse/Adult Family Member of Deceased Patient

All treatment records or spoken information which in any way identifies a client (patient) are considered confidential and privileged to the subject individual in compliance with s.51.30, HFS 92, 42 CFR, Part 2, and 45 CFR Parts 160 and 164. Disclosure without written client (patient) consent or statutory authority is prohibited by law.

APPENDIX A

(Complete if the Child has a Mental Health Diagnosis)

Severe Emotional Disturbance (SED) Criteria Checklist

The child must meet all of the criteria, 1. through 4. below.

Please check all criteria that apply to the child or adolescent you are referring.

1. The child/adolescent must meet **all three** of the following:
- _____ be a child or adolescent under the age of 21; **and**
 - _____ have an emotional disability that has persisted for at least 6 months; **and**
 - _____ that same disability must be expected to persist for a year or longer.
2. The child/adolescent has an emotional and/or behavioral disability that has been diagnosed by a board certified psychiatrist or clinical psychologist (PhD) under the classification system in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) from the following list:

Name of diagnosing psychiatrist or clinical psychologist: _____

Adult diagnostic categories appropriate for children and adolescents include:

- _____ *Substance-Related Disorders* (303.90 – 305.90, not to include caffeine or nicotine-related disorders)
- _____ *Schizophrenia and Other Psychotic Disorders* (293.81, 293.82, 295.10 – 295.90, 297.1, 297.3, 298.9)
- _____ *Mood Disorders* (293.83, 296.00 – 296.90, 300.4, 301.13, 311)
- _____ *Anxiety Disorders* (293.89, 300.00 – 300.02, 300.16 – 300.3, 300.7, 308.3, 309.81)
- _____ *Somatoform Disorders* (300.11, 300.81)
- _____ *Sexual and Gender Identity Disorders* (302.2 – 302.6, 302.85, 302.89, 302.9)
- _____ *Impulse-Control Disorders* (312.30, 312.33, 312.34)
- _____ *Adjustment Disorders* (309.0, 309.24 – 309.4, 309.9)
- _____ *Personality Disorders* (coded on Axis II: 301.0, 301.20 – 301.9)

Disorders usually first diagnosed in infancy, childhood, or adolescence include:

- _____ *Pervasive Developmental Disorders* (299.00, 299.10, 299.80)
- _____ *Attention-Deficit and Disruptive Behavior Disorders* (312.8, 312.9, 313.81, 314.00 – 314.9)
- _____ *Tic Disorders* (307.20, 307.22, 307.23)
- _____ *Feeding and Eating Disorders* (307.1, 307.51, 307.52, 307.53, 307.59)
- _____ *Other Disorders of Infancy, Childhood, or Adolescence* (307.3, 309.21, 313.23, 313.89)

3. The child/adolescent shows **either A. Symptoms or B. Functional Impairments**.
- A. Symptoms** – the child/adolescent must have **one** of the following
- _____ *Psychotic symptoms* – serious mental illness (e.g. schizophrenia) characterized by defective or lost contact with reality, often with hallucinations or delusions.
 - _____ *Danger to self, others and property* as a result of emotional disturbance. The individual is self destructive, e.g., at risk for suicide, runaway, promiscuity, and/or at risk for causing injury to persons or significant damage to property.

B. Functional Impairment in two of the following capacities (compared with expected developmental level):

- _____ *Functioning in self care* – Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.
- _____ *Functioning in community* – Impairment in community function is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which results in potential involvement or involvement in the juvenile justice system.
- _____ *Functioning in social relationships* – Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
- _____ *Functioning in the family* – Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g. fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).
- _____ *Functioning at school/work* – impairment in any **one** of the following:
 - _____ Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame – e.g. consistently failing grades, repeated truancy, expulsion, property damage or violence toward others; **or**
 - _____ Identified as having an Emotional/Behavioral Disability (EBD) under ch. PI 11 and 115.76 WI Statutes; **or**
 - _____ Impairment at work is the inability to conform to work schedule, poor performance, poor relationships with supervisor and other workers, hostile behavior on the job.

4. The child/adolescent is receiving services from two or more of the following service systems: **Please complete "Service Provider Information" on page 2 for each service selected.**

- _____ Mental Health
- _____ Social Services
- _____ Child Protection Services
- _____ Juvenile Justice
- _____ Special Education
- _____ Alcohol & Other Drug Abuse Services

Eligibility Criteria Waived Under Certain Circumstances for Day Treatment of Intensive In-Home Psychotherapy under HealthCheck:

This individual would otherwise meet the definition of SED but has not yet received services from more than one system, but, in judgment of the medical consultant, would be likely to do so were the intensity of treatment requested could not be provided. Please explain: _____

This individual would otherwise meet the definition of SED but functional impairment has not persisted for six months but, in the judgment of the medical consultant, the nature of the acute episode is such that such impairment in functioning (as defined in the definition of SED above) is likely to be evident without the intensity of treatment requested. Please explain: _____

