|  |  |  |
| --- | --- | --- |
| Date:  | Referral for: |  Guidance Care Center (GCC)Citrus Health Network (CHN) |
| Referral Agency:  |  | Phone:  |
| Name:  |  | Title:  |
| Email:  |  | Fax:  |

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| **Minimum Criteria for CAT Program Referrals (Ages 11-21. MUST have family participation)** |
| **Does the client have a diagnosed mental health disorder?** | **YES NO** |
| **Does the client have symptoms of a mental health or substance abuse****co-occurring disorder?** | **YES NO** |
| **Is the family (parent/guardian/caregiver) willing to participate?** | **YES NO** |
| **Does the client present with at least ONE of the following risk factors (please check all that apply):** |
| At risk for out-of-home placement (due to repeated failures at less intensive levels of care) Two (2) or more psychiatric hospitalizations or repeated treatment failuresInvolvement with the Department of Juvenile Justice (DJJ) Multiple episodes involving law enforcementPoor academic performance and/or suspensionsOther risk factors(Please List):  |
| **Child Information** |
| **Child’s Name:** |  | **DOB:** |  | **AGE:****(11-21)** |  |
| **Address:** |  | **Phone #:** |  |
| **City:** |  | **State:** |  | **Zip :** |  |
| **School:** |  | **Grade:** |  |
| **Race:** |  | **Ethnicity:** |  | **Language:** |  |
| **Family Placement Information** |
| **Parent/Legal****Guardian/Caregiver Name:** |  | **Relationship****to Client:** |  |
| **Address:** |  | **City:** |  | **Zip:** |  |
| **Work Phone #:** |  | **Phone #:** |  |
| **Emergency Contact/Relationship:** |  | **Phone:** |  |

I, , Client (if 18 or older) or

I ,

Parent / Guardian/ Caregiver, of ,

print parent/guardian/caregiver name/ print child’s name

give my consent for to provide GCC CHN with my contact information

name of provider organization

for provision and eligibility screening for services in the Community Action Team Program.

Parent/Guardian/Caregiver/ Client Signature Date

Provider Organization Representative Date

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| **For Provider Use only:** |
| Date Received: |  | Date Assigned: |  |
| Date Family Called: |  | Intake Date: |  |
| Therapist: |  | Case Manager: |  |