**Referral Form**

Name:

DOB:

Behavioral Health Provider

Dept. of Juvenile Justice/Corrections

School

Citrus Family Care Network

Referral Source Name:

Preferred method of communication:

Referral Date:

Age:

Race:

Ethnicity:

Other:

Gender:

Male

Female

English

Preferred Language:

Spanish

Creole

Other:

Address:

City: Zip code:

Email

Phone

Day

Evening

Email:

Cell Phone:

Parent/Guardian Name (if appropriate):

Email:

Cell Phone:

 **Referral Source:**

Hospital Self-Referral

Faith-Based Organization

Other:

Organization:

Referral Source Phone Number: Email:

 **Eligibility Criteria:**

Age 14-21

Miami-Dade County resident (or their family) Mental health diagnoses:

Anxiety Disorders

Attention Deficit/Hyperactivity Disorder

Bipolar & Related Conduct Disorder Depressive Disorder

Disruptive, Impulse-Control, Conduct Disorder Eating Disorder

Gender Dysphoria

Intermittent Explosive Disorder

**Which Diagnoses do you consider PRIMARY?**

Obsessive-Compulsive & Related Oppositional Defiant Disorder Schizophrenia & Other Psychotic Disorders

Substance Related & Addictions Trauma and Stressor-Related Disorders

Suspected mental health issue due to (describe behaviors):

Diagnostic code/name:

**1**

**1. YOUNG ADULT IS/HAS (check all that apply):**

 Social Security:



 Wraparound

 Transition to Independence Process (TIP)

**Agencies:**

Criminal Justice/Juvenile Court/Corrections/Probation

Child Welfare/Child Protection Services School/Educational Facility

Early Intervention

Family Court

Physical Health Care Agency/Clinic/Provider

**Needs:**

In or at risk of being in any of the following: Out of home residential care center

* School:

Hospital

Correctional Facility

Being discharged from any of the following:

SIPP

Hospital

CSU

Residential program

Correctional Facility

Aging out of foster-care, transitional housing group home, or parent’s home within next 12 months

History of 2 or more admissions that may include hospitalizations, incarcerations, etc.

Has been in and out-of-home treatment facility in the past year

A level of Care assessment has indicated at risk status (CFARS/FlashFARS)

Mental Health history: they received services?

No

Yes, and have

past or

present

* Provider:

Substance Use history: they received services?

No

Yes, and have

past or present

* Provider:

Intellectual Disabilities: they received services?

No

Yes, and have

past or

present

* Provider:

Experiencing above issues for at least one year and/or expected to require involvement of above agencies for more than a year

History of trauma or abuse Pregnant or Parenting

Unaccompanied youth, homeless or at risk of homelessness

Unemployed or underemployed; no income

History of trauma or abuse

Currently not in school and does not have diploma/GED:

* Most recent grade completed:

Document supporting Diagnosis/Disability (affidavit from a licensed professional, recent

biopsychosocial, etc. - refer to policy)

Consent/Release of Information Form

**Name/Agency**

**Electronic Signature (Initials)**

**Date**

**2**

**REFERRAL SOURCE SIGNATURE REQUIRED:**

**CONFIRM THAT THE FOLLOWING DOCUMENTS ARE INCLUDED WITH THIS FORM:**

**4. OTHER CHALLENGES:**

**3. DURATION:**

**2. SYSTEM INVOLVEMENT (check all that apply):**