INTEGRATED SERVICES
for behavioral health

Referral to Mary Hill Youth and Family Center (MHYFC)

PERSON FILLING OUT FORM:_____ DATE:_____
Phone: _____ EMAIL: _____

Youth's First Name: _____Middle Name: _____

Youth's Last Name: _____SOC SEC #: _____
DOB:_____ Age:_____
Race: (OPTIONAL)_____ Height:_____
Weight:_____ Hair Color: _____
Eye Color: _____ Gender: _____
Gender Identity: _____

IS YOUTH CURRENTLY USING SUBSTANCES_____ **IS YOUTH PREGNANT_____**

Does youth have children: _____If so, please list names and:_____
_____
_____

REFFERAL RECORD

***Attach copy of CANS assessment notating that residential level of care is indicated (CANS will be required within 30 days of admission if not initially available).**

Agency:_____
Agency contact: _____
Address:_____ City:_____State:_____Zip: _____
Phone #: _____

List youth's current behaviors and treatment goals and why they are being referred for residential care:

_____
_____
_____

PERMANENCY PLAN: (What natural supports does youth currently have in place, who will visit and call youth besides providers?)

_____
_____

PLACEMENT HISTORY

Youth's current living arrangement: _____
Please list placements youth has experienced in the past 12 months: _____
_____
_____

CUSTODY INFORMATION

Who has custody of youth: _____

Is there shared parenting: _____

Relationship to youth: _____

Address of custodian: _____City: _____State: ____Zip:_____

Phone #: _____

EMERGENCY CONTACTS

Emergency contact name: _____

Phone number:_____Relationship to youth: _____

Emergency contact name: _____

_____

Phone number:_____Relationship to youth: _____

BIOLOGICAL PARENTS (if applicable)

Mother's name: _____

Mother's address:_____City:_____

State:_____Zip:_____Phone number: _____

Father's name: _____

Father's address:_____City:_____

State:_____Zip:_____Phone number: _____

ADOPTIVE/ FOSTER PARENTS (if applicable)

Mother's Name:_____

Mother's address:_____City:_____

State:_____Zip:_____Phone number: _____

Father's Name: _____

Father's address:_____City:_____

State:_____Zip:_____Phone number: _____

LEGAL INFORMATION

Does youth have legal involvement: Y OR N

On probation: Y OR N Are charges pending : Y OR N Court ordered: Y OR N

Consequences if treatment is not completed:_____

Court name: _____

Court address:_____City:_____

State:_____Zip:_____Phone number:_____

Probation office:_____Phone number: _____

Probation officer's emergency contact number: _____

Previous misdemeanors: _____ Previous felonies: ____ Number of times in detention center:_____

ABUSE INFORMATION

Sexually abused: Y OR N Age and sex of perpetrator: _____ Briefly explain nature of abuse: _____

_____

Has youth been charged in a sexual crime: Y OR N Explain: _____

Physically abused: Y OR N Explain: _____

Domestic violence: Y OR N Victim__ Perpetrator__ or Witness__

Explain: _____

Has any of the above been reported: Y OR N If so to whom**:** _____

MENTAL HEALTH INFORMATION

Has youth attempted suicide: Y OR N

Number of attempts:_____Date of most recent attempt:_____Attempt method:_____

Did youth need medical care: Y OR N

Was youth admitted as an inpatient due to suicide attempt: Y OR N Is youth stable now: Y OR N

Current suicide risk: Low Med High Does youth have a suicide plan: Y OR N

Has youth engaged in any type of self-harm: Y OR N

Nature of the harm: cutting burning breaking bones___Other: _____Explain:_____

When was the last incident:_____

Has youth been diagnosed with a mental health disorder: Y OR N

List Diagnoses: _____

Diagnosed by: _____

Current mental health (psychotropic) medications: _____

_____

_____

PAST OUTPATIENT MENTAL HEALTH TREATMENT

Number of past mental health services:___ Last discharge date: _____

Name of program treated at most recently: _____

Address: _____City: _____State:_____Zip:_____

Phone number: _____

Provider of psychiatric/psychological services: _____ Diagnosis:_____

PAST INPATIENT MENTAL HEALTH TREATMENT

Number of past inpatient mental health services: _____Last Discharge date: _____

Name of program treated at most recently: _____

Address:_____City_____

State: __ Zip:_____Phone number: _____

Provider of psychiatric/psychological services: _____ Diagnosis: _____

VIOLENT BEHAVIOR RECORD

Does youth have a history of violent behavior: Y OR N If yes when was last episode: _____

If yes is behavior related to a mental health diagnosis: Y OR N

Type of violent behavior: _____

To Family: Y OR N Peers: Y OR N Strangers: Y OR N Is youth an assault risk currently: Y OR N

To Animals: Y OR N Is youth stable now: Y OR N

History of starting fires: Y OR N

When _____Where _____

SCHOOL INFORMATION

Does youth attend: Regular School _____Online School_____Home School GED _____ Other educational program: _____ Do you give permission for youth to work towards a GED: Y OR N

School name: _____

School Address:_____ City_____

State:_____Zip:_____ Phone number:_____ Principal/counselor's name: _____

Phone number: _____ IEP Y OR N Special Education: Y OR N

**If youth has IEP please attach copy.*

Please list any learning disabilities: _____

Suspensions: Y OR N Explain: _____

Expulsions: Y OR N Explain: _____

MEDICAL INFORMATION

Please list all medications youth is CURRENTLY taking: _____

_____

_____

Has youth ever overdosed: Y OR N Accidental: Y OR N

When and on What: _____ Serious head injury: Y OR N Explain: _____

List any serious/chronic medical issues: _____

Seizures: Y OR N When was last episode: _____

Dental Problems: _____ Physical disabilities: _____Dietary restrictions: _____

Food allergies: _____ Allergies to medications: _____

Eating Disorders: Y OR N Anorexia: Y OR N Bulimia: Y OR N Is this current: Y OR N

Is Youth medically stable: Y OR N

Birth control: Y OR N STD'S: Y OR N Diagnosis: _____

Heart murmurs or heart conditions: Y OR N Describe: _____

Immunizations up to date: Y OR N

**A copy of a negative Tuberculosis (TB) Mantoux Skin Test will be required for admission.*

HOSPITAL/PHYSICIAN INFORMATION

Does youth have a primary care physician: Y OR N IF YES, Primary Care Physician's Name: _____

Address: _____ City_____

State: _____ Zip: _____ Phone number: _____

IF NO, where does youth receive medical care: _____

Address:_____City _____State: Zip:____Phone number: _____

Any major medical treatment within the last 24 months: Y OR N

Explain:_____ Name of Hospital: _____

Address:_____City_____

State:_____ Zip:_____ Phone number:_____

THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY

MEDICAID INFORMATION

Does youth have Medicaid: Y OR N

If yes, Medicaid billing number:_____

Name of county that issued the Medicaid:_____

Name of Managed Care Provider: _____

If youth does not have Medicaid and is eligible, who will apply? _____

INSURANCE INFORMATION (if applicable)

Name of primary insurance company: _____

Address:_____City:_____

State:_____ Zip:_____Phone number: _____

Pre-Authorization phone number: _____

Mental Health/substance abuse phone number: _____

Policy holder/subscriber: _____

Policy holder/subscriber's address: _____

City_____State:_____ Zip:_____Phone number: _____

Policy holder's relationship to youth: _____

Group number:_____Plan Number: _____ Name of employer: _____

Address:_____City_____

State: Zip: ____Phone number:_____Additional information: _____

Name of secondary insurance company:_____

Address:_____City_____

State: Zip:_____Phone number: _____

Pre-Authorization phone number:_____

Mental Health/substance abuse phone number: _____

Policy holder/subscriber: _____

Policy holder/subscriber: _____Address:_____

City:_____ State:_____ Zip:_____ Phone number:_____

Policy holder's relationship to youth: _____

Group number:_____

Plan Number: _____ Name of employer: _____

Address:_____City_____

State: Zip: _____Phone number: _____ Additional information: _____