JUSTICE WORKS BEHAVIORAL CARE REFERRAL

TRAUMA INFORMED | INTERVENTION BASED | FAMILY FOCUSED | FLEXIBLE | GOAL DRIVEN

Date: _____

Reason for referral/statement of need

Services interested in:

- ☐ Diagnostic Assessment
- ☐ Parenting Assessment
- ☐ Therapy Services
- ☐ Behavioral Services
- ☐ Family Support
- ☐ Unsure
- ☐ Life/Social Skills
- ☐ Other _____

** A licensed therapist will make the final recommendation regarding what services would be most effective for your treatment.

REFERRING PERSON INFORMATION

Name _____ Email _____ Is this a self-referral? ◯ Yes ◯ No

Organization Name and Address

_____ Phone Number _____

CLIENT INFORMATION

Client Name _____ Nickname _____

Email Address _____ Phone Number _____

Age _____ DOB _____ Gender ◯ Male ◯ Female ◯ Other

Client's Current Street address. City. State. Zip Code

_____

Is client identified as a member of a federally registered NATIVE AMERICAN tribe? ◯ Yes ◯ No

Out of Home Placement: ◯ Adoptive Parent ◯ Foster Home ◯ Theraputic Foster Home ◯ Group Home ◯ Residential Treatment ◯ Hospital ◯ Other _____

Facility Name _____ Discharge Date: _____

CAREGIVER CONTACT INFORMATION

Name _____ Phone Number _____

Email Address _____ Relationship to Client _____

Name _____ Phone Number _____

Email Address _____ Relationship to Client _____

Have parental rights been terminated? ◯ Yes ◯ No

INVOLVED AGENCY CONTACT INFORMATION

Involved Agency ☐ COC ☐ DJJ ☐ DSS ☐ DMH ☐ DDSN ☐ GAL ☐ Other _____

Guardian Ad Litem Name _____ Email _____

Caseworker Name _____ Email _____

Caseworker Supervisor Name _____ Email _____

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CLIENT INSURANCE INFORMATION

☐ Agency pay ☐ Medicaid ☐ Blue Cross Blue Shield ☐ Self-pay

MEDICAID

MEDICAID ID # _ _ _ _ _ _ _ _ _ _ _

OR SOCIAL SECURITY # _ _ _ - _ _ - _ _ _ _

BLUE CROSS BLUE SHIELD

POLICY# _____

POLICY HOLDER: _____

***MUST SCAN FRONT AND BACK OF BCBS INSURANCE CARD AND SUBMIT WITH REFERRAL

→ Please include secondary insurance if applicable

POLICY# _____

POLICY HOLDER: _____

CLIENTS MENTAL/BEHAVIORAL HEALTH INFORMATION

Is client currently receiving any therapy services? ◯ Yes ◯ No

Office & Clinician Name _____

Please list any other current or historical mental health services that the client has received. (ie: Behavioral Modification. Therapy. Family Support Services. Psychosocial Rehabilitative Services)

Current Medications (name | dosage | prescribed by)

Current diagnosis (if any is known)

HAS THE CLIENT HAD ANY OF THE FOLLOWING:

CALOCUS ◯ YES ◯ NO ◯ UNSURE IF YES. DATE: _____ Which Organization? _____

Diagnostic Assessment ◯ YES ◯ NO ◯ UNSURE IF YES. DATE: _____ Which Organization? _____

Psychiatric Evaluation ◯ YES ◯ NO ◯ UNSURE IF YES. DATE: _____ Which Organization? _____

SEND ABOVE DOCUMENTS WITH REFERRAL (INCLUDING CALOCUS, CBCL, DIAGNOSTIC ASSESSMENT, PSYCHOLOGICAL, MEDICAL, OR PROGRAM NOTES, DISCHARGE NOTES, ETC.)

JUSTICE WORKS BEHAVIORAL CARE REFERRAL

CLIENT STRENGTHS (CHECK ALL THAT APPLY)

- ☐ Strong Family Support
- ☐ Appropriate Reading Level
- ☐ Resiliency/Coping Skills
- ☐ Other Personal Support
- ☐ Average/Above IQ
- ☐ Good Socialization Skills
- ☐ On Grade-Level
- ☐ Good Verbal Skills
- ☐ Good Personal Hygiene
- ☐ Other _____

CLIENT PROBLEMS (CHECK ALL THAT APPLY)

- ☐ Anxiety
- ☐ Steals
- ☐ Impulsive
- ☐ Trust Issues
- ☐ Lies
- ☐ Bed-wetting
- ☐ Expelled
- ☐ Unruly
- ☐ Verbal Aggression
- ☐ Alcohol/Drug Use
- ☐ Low Self-Esteem
- ☐ Victim of Abuse
- ☐ Victim of Neglect
- ☐ Not in School
- ☐ Suicide attempts
- ☐ Other _____
- ☐ Difficulty with Authority
- ☐ Cruelty to Animals
- ☐ Attachment Issues
- ☐ Victim of Sexual Abuse
- ☐ Sexually Provocative
- ☐ Sibling Related Difficulty
- ☐ Sexually Inappropriate
- ☐ Hyperactive
- ☐ Manic/Mood Swings
- ☐ Poor Personal Hygiene
- ☐ Poor Coping Skills
- ☐ Problems at School
- ☐ Fire Setting/Arson
- ☐ Self-Destructive Behaviors
- ☐ Attention Seeking
- ☐ Gang Involvement
- ☐ Criminal Behavior
- ☐ Suicidal Ideation
- ☐ Physical Aggression
- ☐ Destroys Property
- ☐ Defiant/Oppositional

List any current or prior medical conditions, physical disabilities, adaptive devices, or specialty medical care that a provider needs to accommodate.

CLIENT SCHOOL INFORMATION

Is client currently attending school? ◯ yes ◯ no

if yes, name of school _____

If no, why? _____

Does the client have a current IEP? ◯ Yes ◯ No Date? _____

Does the client have a section 504 plan? ◯ Yes ◯ No Date? _____

WE ARE HERE TO HELP! PLEASE CALL US IF YOU HAVE ANY QUESTIONS ABOUT HOW TO COMPLETE THIS FORM. WE NEED ALL OF THE INFORMATION SO THAT WE CAN PROCEED AS QUICKLY AS POSSIBLE WITH THE BEST COURSE OF TREATMENT!

For questions please call: 843-974-5934

email your referral to:

REFERRALS@JUSTICEWORKSBC.ORG

or fax: 803-766-7801

Updated 01/2020