

Healthy Families Program Referral Form

Enrollee's Name: _____	DOB: _____	SSN/Membership #: _____
Parent/Guardian Name: _____	Phone: () _____	
Address: _____		
Enrollee's Primary Languages: _____		
Guardian/Caretaker's Primary Language: _____		

Enrollee's Healthy Families Health Plan: _____	Date: _____	
Referring Party: _____	Phone: () _____	FAX: () _____
<input type="checkbox"/> Designated Health Plan (HP) Representative (e.g. Care Coordinator, Case Manager, etc.) <input type="checkbox"/> HP Primary Care Provider		
<input type="checkbox"/> HP Mental Health Provider <input type="checkbox"/> HP Alcohol & Other Drug (AOD) Service Provider		
Address: _____		
Enrollee's Primary Care Physician (if known): _____	Phone: () _____	
Address: _____	FAX: () _____	

Enrollee's Known/Suspected Mental Health Diagnosis (if any): _____
Does this Enrollee also have a Suspected/Known Alcohol & Other Drug Abuse Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", list Suspected/Known AOD Diagnosis: _____
Enrollee's Known/Suspected Medical Diagnosis (if any): _____
Enrollee's Current Medication (if any): _____
Date of Enrollee's Last WELL CHILD EXAM (if known): _____
Is the Enrollee currently receiving in-patient psychiatric services? <input type="checkbox"/> Yes <input type="checkbox"/> No

<p>Reason(s) for Referral: Indicate the reason(s) you believe the Enrollee MAY be qualified for services for children with Severe Emotional Disturbance (SED).</p> <p>A. As a result of a mental disorder the Enrollee has substantial impairment in the following areas:</p> <ul style="list-style-type: none"><input type="checkbox"/> self-care<input type="checkbox"/> school functioning<input type="checkbox"/> family relationships<input type="checkbox"/> ability to function in the community <p>B. <input type="checkbox"/> The Enrollee is at risk for removal from his/her home.</p> <p>C. <input type="checkbox"/> The mental disorder/impairments have been present for six months, or are likely to continue for more than one year without treatment.</p> <p>D. <input type="checkbox"/> The Enrollee displays: psychotic features, risk of suicide, risk of violence due to mental disorder.</p>

THE FOLLOWING INFORMATION WILL FACILITATE A THOROUGH MENTAL HEALTH DEPARTMENT EVALUATION

Please check applicable boxes. Following each statement are examples of specific behaviors that may have initiated this referral. Please circle any that apply. This is not meant to be exhaustive. If you have a question about whether to check "Yes", please indicate under the COMMENTS section at the end of the form.

- 1. *This child is or may be a danger to him/herself or to others.*
Child may have attempted suicide; made suicidal gestures; expressed suicidal ideation; is assaultive to other children or adults; is reckless and routinely puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.
- 2. *This child has or may have a history of severe physical or sexual abuse or has been exposed to extreme violent behavior.*
Child's history involves either being subject to or has witnessed extreme physical abuse, domestic violence or sexual abuse, e.g., severe bruising in unusual areas, being forced to watch torture or sexual assault, witness to murder, etc.
- 3. *This child has or may have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy.*
Child may have persistent chaotic, impulsive or disruptive behaviors, may have daily verbal outburst; refuse to follow basic rules; may constantly challenge authority of adults or attempt to undermine the authority of caregiver with other children; may require constant direction and supervision in all activities; may require total attention of caregiver and be overly jealous of caregiver's other relationships; may be in constant motion which is uncontrolled by medication; may wander the house at night; may be truant from school regularly and not respond to limit-setting or other discipline, etc.
- 4. *This child exhibits or may exhibit bizarre or unusual behaviors.*
Child may have a history or pattern of fire-setting; may be cruel to animals; may masturbate excessively, compulsively and/or publicly; may appear to hear voices or respond to other internal stimuli (including alcohol-or drug-induced); may have repetitive body motions (e.g., head banging) or vocalizations (e.g., echolalia); may have a patter of smearing feces, etc.
- 5. *The child has or may have problems with social adjustment.*
The child is regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; is regularly truant from school; steals; regularly lies; is mute; is confined due to serious law violations; does not seem to feel guilt after misbehavior, etc.
- 6. *This child has or may have problems making and maintaining healthy relationships.*
Child is unable to form positive relationships with peers; may provoke other children to victimize him/her; is involved with gangs or expresses the desire to be; does not form bond with caregiver, etc.
- 7. *This child has or may have problems with personal care.*
Child eats or drinks substances that are not food; is regularly enuretic during waking hours (subject to age of child); refuses to tend to personal hygiene to an extreme.
- 8. *This child has or may have significant functional impairment.*
There is no known history of developmental disorder and the child's behavior interferes with his/her ability to learn at school; he/she is significantly delayed in language; is "unsocialized" and incapable of managing basic age appropriate skills; is selectively mute, etc.
- 9. *This child has or may have significant problems managing his/her feelings.*
Child has severe temper tantrums; screams uncontrollably, cries inconsolably; has significant and regular nightmares, is withdrawn and uninvolved with others, whines or pouts excessively and regularly; expresses the feeling that others are out to get him/her, worries excessively and is preoccupied compulsive with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; is constantly restless or over active; etc.
- 10. *This child has or may have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medications.*
Child has history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.
- 11. *This child is known to use/abuse alcohol and/or drugs.*
Child uses alcohol or other drugs.

Additional comments regarding behavior, symptoms, medical condition, or other relevant information: _____

Signature: _____

Date: _____