

CHILDREN'S SERVICES REFERRAL APPLICATION

MATCHBOX HEALTH SERVICES

Date: _____

Date Placement Needed: _____

Type of Referral:

Group Living High
Supervised Independent Living
Therapeutic Foster Care/Family Living

Group Living Moderate
Crisis Stabilization
Moderate

CLIENT INFORMATION

Consumer's Name: _____ Social Security Number: _____

Alias: _____ Medicaid Number: _____

Date of Birth _____ Age _____ Sex _____ Weight _____ Height _____

Religious Affiliation _____ Protestant _____ Catholic _____ Muslim _____ None
_____ Jewish _____ Other (specify) _____

County of Legal Custody: _____ Place of Birth: _____

Distinguishing Features (i.e. scars, birthmarks, etc.): _____

Strength: _____ Strong Family Base _____ Appropriate Reading Level _____ Good Personal Hygiene
_____ Average/Above IQ _____ Impulse Control _____ Good Social Skills
_____ Good Verbal Skills _____ Appropriate Coping Skills Other: _____

Weakness: _____ Functionally Illiterate _____ Weak Family Base
_____ Low IQ _____ Poor Personal Hygiene
_____ Poor Social Skills Other: _____

MEDICAL INFORMATION

Diagnosis

DSM IV Dx: Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

IQ: _____ Verbal _____ Performance _____ Full Scale

Examiner: _____ Date: _____

LOE: _____ CAFAS: _____ GAF: _____

Medications

Dosage

Instructions

CHILDREN SERVICES REFERRAL APPLICATION

MEDICAL INFORMATION (Con't)

Medical Conditions (past and present):

<input type="checkbox"/> Lice	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Eczema
<input type="checkbox"/> Anemia	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Measles	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Mumps	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Ringworm	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Migraine Headaches	Other: _____

Date of last Physical Exam: _____ Last Dental Exam: _____ Last Eye Exam: _____

Allergies: _____

Dental Appliances: Yes No Contacts/Glasses: Yes No

Medical Insurance Company: _____

Insurance Policy Number: _____

Insurance is in who's name?: _____

Special Dietary Needs: _____

CONSUMER'S PRIMARY REFERRAL SOURCE INFORMATION

Referring Agency: OJJ AMH DSS

Other: _____

Case Manager's Name: _____ Phone#: _____

Address: _____

Legal Custodian: _____ Relationship: _____

Address: _____ Phone #: () _____

Contact Person(s): _____

Telephone Numbers(s): _____

Reason for Referral: _____

PLACEMENT HISTORY

Placement (Begin w/Current Placement)	Dates (From-To)	Reason for Discharge

CHILDREN'S SERVICES REFERRAL APPLICATION

CURRENT BEHAVIORAL PROBLEMS

<input type="checkbox"/> Abandonment Issues	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arson
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Antisocial Behavior	<input type="checkbox"/> Difficulty With
<input type="checkbox"/> Assaultive (Physical)	<input type="checkbox"/> Assaultive (Sexual)	<input type="checkbox"/> Assaultive (Verbal)
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Destroying Property	<input type="checkbox"/> Fire Setter	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Homeless	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Impulsive
<input type="checkbox"/> Lying	<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Loss/Grief Difficulties
<input type="checkbox"/> Physical Impairment	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Parent Neglect Issues
<input type="checkbox"/> Perception of Reality	<input type="checkbox"/> Phobic Behavior	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Oppositional	<input type="checkbox"/> Self Destructive Behavior	<input type="checkbox"/> Sibling Related Difficulty
<input type="checkbox"/> Social Immaturity	<input type="checkbox"/> Sexually Inappropriate	<input type="checkbox"/> Stealing
<input type="checkbox"/> Suicidal	<input type="checkbox"/> Behavior	<input type="checkbox"/> Running Away
<input type="checkbox"/> Unruly/Ungovernable	<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Truancy

Other: _____

History of Abuse:

Victim of Neglect

Victim of Physical Abuse

Victim of Sexual Abuse

Victim of Emotional Abuse

FAMILY INFORMATION

Biological Mother's Name: _____

Address: _____

Telephone Number: _____

Race: _____ Education Level: _____ Criminal Record: _____

Are Parents: Married Separated Divorced Never Married Deceased

Have their parental rights been terminated?: If so, when?: _____

How many siblings does consumer have?: _____ Are siblings in out-of-home placement?: _____

If yes, please specify:

DSS Foster Care

Relatives

Incarcerated

Group Home

Other: _____

COURT HISTORY

Does Client have a criminal record? _____ Yes _____ No

Offense

Conviction Dates

Pending Charges: _____

Is client on probation?: _____

Is placement court ordered? _____ Yes _____ No

TREATMENT GOAL

Clients Goal	
Family Goals	
Agency Goals	
Educational Goals	

Name of Person Making Referral: _____

Telephone: _____

Pager: _____

Fax: _____

Address: _____