

Putnam County Universal Referral Form

CONFIDENTIAL

*** Attach Consent Form ***

To:

<input type="checkbox"/> CDS Family & Behavioral Health Svcs.	<input type="checkbox"/> Stewart Marchman Act
<input type="checkbox"/> Children's Home Society	<input type="checkbox"/> United Vision Program
<input type="checkbox"/> Department of Juvenile Justice	<input type="checkbox"/> Department of Children and Families
<input type="checkbox"/> WorkSource	<input type="checkbox"/> Putnam County School District: (list School) _____
<input type="checkbox"/> White Foundation	<input type="checkbox"/> Health Department (Program) _____
<input type="checkbox"/> Juvenile Crime Prevention Office	<input type="checkbox"/> Other: (List) _____

From:

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<input type="checkbox"/> White Foundation	<input type="checkbox"/> Health Department (Program) _____
<input type="checkbox"/> Juvenile Crime Prevention Office	<input type="checkbox"/> Other: (List) _____

Referral Information

Client Name: _____ Age: _____ Gender: Male Female
First MI Last

Current Mailing Address: _____ City: _____

State: Florida Zip Code: _____ Home Telephone Number: () or ()

Social Security Number: _____ Date of Birth: _____

Client is aware of and approves this referral: Yes No _____
Signature of Client Date

If client is a minor, complete the following section

Child lives with: Parent(s) In Foster Care Relatives Other: (List) _____

Name of person(s) with whom Child lives: _____

If Child does not live with his/her parent(s), provide name and address of parent(s): _____

The Child: Does Not OR Does attend school - Name of School: _____ Grade: _____

FOR DCF FAMILY SAFETY REFERRALS:

Has Child been sheltered by the Department? No Yes -- If yes, attach shelter order

Has Child been found dependent and gone to disposition hearing? No Yes -- If yes, attach disposition order

Has child been judicially reviewed since disposition? No Yes -- If yes, attach judicial review order

The Client Currently Receives the Following Service(s) from our Agency:

<input type="checkbox"/> None	<input type="checkbox"/> Counseling: <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Social Work Case Management
<input type="checkbox"/> Psychiatric/Medication Services	<input type="checkbox"/> Intake for Juveniles
<input type="checkbox"/> Probation for Juveniles	<input type="checkbox"/> Diversion for Juveniles
<input type="checkbox"/> Aftercare	<input type="checkbox"/> Transportation, Clothing Assistance, Childcare, Work Activity
<input type="checkbox"/> Family Safety (PI, PS, Foster Care)	<input type="checkbox"/> Medicaid Targeted Case Management
<input type="checkbox"/> Domestic Violence Shelter/Counseling	<input type="checkbox"/> Interface
<input type="checkbox"/> Children's SAMH Assessment	<input type="checkbox"/> Counseling/Case Mgt For Runaway, Truant, Ungovernable Youth
<input type="checkbox"/> Assessment Services	<input type="checkbox"/> Day Treatment
<input type="checkbox"/> Other: (List) _____	

The Client Needs the Following Service(s):

- Counseling/Case Mgt. For Runaway, Truant or Ungovernable Youth
- Psychological Evaluation
- SAMH Assessment
- Mental Health Evaluation to Determine Need for Medication
- Child or Adult Mental Health Targeted Case Management
- In-School Services (Counseling)
- Parenting Class or In-Home Parenting
- Anger Management
- Mental Health Counseling
- Children's Intervention/Prevention Substance Abuse Services
- Social Work Case Management (parenting skills, money mgt, time mgt, job skills/training, housekeeping skills, etc.)
- In-Home Services: Homebuilders Other (List): _____
- Other, (List): _____

I am Referring the Client Because: *(check all that apply)*

- Signed, Current Court Order that specifies the services. A copy of the court order: is OR is not enclosed
- See enclosed prior documentation with specific recommendations:
 - SAMH Assessment Psychological Evaluation Psychosocial Evaluation Psychiatric Evaluation
- Screening indicates possible mental health problem. A Copy of the Screening Tool is enclosed
- Screening indicates possible substance abuse problems. A Copy of the Screening Tool is enclosed
- Case Plan mandates Anger Management and/or parenting program. Copy of the Plan: is OR is not enclosed
- Case Plan requires Counseling. A copy of the Case Plan: is enclosed OR is not enclosed
- Client is a minor without legal charges, and has a history of: Truancy Runaway Family Discord
- Client needs help with parenting skills, managing money, housekeeping skills, accessing social services, job skills, etc. and other social work case management/Counseling
- Other (List): _____

Client has been referred to the Following Agencies:

- CDS Family & Behavioral Health Svs., for: _____
- Stewart Marchman Act, for: _____
- Children's Home Society, for: _____
- Other: _____ For: _____

Client: Has Medicaid Is TANF Eligible Has Private Insurance Has No Insurance Status Unknown

Comments or Additional Information: _____

Name and Title of Person Making Referral: _____

Telephone Number of Person Making Referral: _____ EXT: _____

Mailing Address and Agency of Person Making Referral: _____

Signature of Person Making Referral

Date