

**Community Service Board of Middle Georgia**

**HOPE Intensive Customized Care Coordination (IC3) Wraparound Referral Request Form**

We are here for you. Contact us at:

478-275-6850 hope@csbmg.com

# Youth Information

|  |  |  |
| --- | --- | --- |
| Legal Name:  Date of Birth: Date of Referral: | | Preferred Name:  Primary Phone Number:  Current Grade:  Primary Language:  Relation to youth:  Email Address:  Other |
| Current Address:  Current School:  Current Age: Race:  Parent/Caregiver Name:  Physical Address: Mailing Address:  Secondary/Work Phone Number: Birth Gender: Male | Female |

Gender Identity: Male Female Non-binary Other Prefer not to Disclose

Referred by: Relation to youth:

Referral Source Contact Info (Phone/Email/Other): Is youth in DFCS custody? Yes No

Is youth under DJJ supervision or in a DJJ facility? Yes No

|  |  |
| --- | --- |
| Primary Insurance:  Secondary Insurance: | Policy Number:  Policy Number: |

# Behavioral/Mental Health Background

|  |  |
| --- | --- |
| Agency Name:  Contact Phone:  Primary Mental Health Diagnosis:  Clinic/Agency:  Secondary Mental Health Diagnosis:  Clinic/Agency:  Substance Use Diagnosis:  Clinic/Agency:  Medical Diagnosis: | Contact Name:  Contact Email:  Date of Diagnosis:  Diagnosed by:  Date of Diagnosis:  Diagnosed by:  Date of Diagnosis:  Diagnosed by:  Date of Diagnosis: |
| Clinic/Agency: | Diagnosed by: |

Is youth currently prescribed and/or taking medications? Yes No

If yes, what medications?

|  |  |
| --- | --- |
| Primary Care Physician: | Phone Number: |
| Mental Health Clinician: | Phone Number: |

Does youth have a current CANS? Yes No

If yes, please attach.

Has the youth experienced any of the following behaviors or emotional expressions below

No ConcernSome ConcernNeeds Attention

|  |  |  |  |
| --- | --- | --- | --- |
| Psychosis |  |  |  |
| Attention/Concentration |  |  |  |
| Impulsivity |  |  |  |
| Depression |  |  |  |
| Anxiety |  |  |  |
| Substance Abuse |  |  |  |
| Attachment Difficulties |  |  |  |
| Anger Control |  |  |  |
| PTSD |  |  |  |
| Phobias |  |  |  |
| Obsession/Compulsion |  |  |  |

Exposure to Potentially Traumatic/Adverse Childhood Experiences

No exposurePast exposure Currently exposed or

causing some experience moderate

difficulties nowto extreme difficulties as result

|  |  |  |  |
| --- | --- | --- | --- |
| Sexual Abuse |  |  |  |
| Physical Abuse |  |  |  |
| Emotional Abuse |  |  |  |
| Neglect |  |  |  |
| Witness to Family Violence |  |  |  |
| Community Violence |  |  |  |
| School Violence |  |  |  |
| Disruptions in  Caregiving/Attachment Losses |  |  |  |

Life Functioning Needs

No difficultiesSome difficultiesModerate-Extremedifficulties

|  |  |  |  |
| --- | --- | --- | --- |
| Family |  |  |  |
| Living Situation |  |  |  |
| Social Functioning |  |  |  |
| Legal |  |  |  |
| Sleep |  |  |  |
| Recreational |  |  |  |
| School Behavior |  |  |  |

Current Clinical Information: Anxiety Disorders

MildModerateSevereAcuteChronicN/A

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Obsession/Compulsion |  |  |  |  |  |  |
| Generalized Anxiety |  |  |  |  |  |  |
| Panic Attacks |  |  |  |  |  |  |
| Phobias |  |  |  |  |  |  |
| Somatic Complaints |  |  |  |  |  |  |
| PTSD Symptoms |  |  |  |  |  |  |

Current Clinical Information: Mania

MildModerateSevereAcuteChronicN/A

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Insomnia |  |  |  |  |  |  |
| Grandiosity |  |  |  |  |  |  |
| Pressured Speech |  |  |  |  |  |  |
| Racing Thoughts /Flight of Ideas |  |  |  |  |  |  |
| Poor Judgement /Impulsiveness |  |  |  |  |  |  |

Current Clinical Information: Psychotic Disorders

MildModerateSevereAcuteChronicN/A

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Delusions /Paranoia |  |  |  |  |  |  |
| Self-Care Issues |  |  |  |  |  |  |
| Hallucinations |  |  |  |  |  |  |
| DisorganizedThoughtProcess |  |  |  |  |  |  |
| Loose Associations |  |  |  |  |  |  |

Current Clinical Information: Depression

MildModerateSevereAcuteChronicN/A

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Impaired Concentration |  |  |  |  |  |  |
| Impaired Memory |  |  |  |  |  |  |
| Psychomotor Retardation |  |  |  |  |  |  |
| Sexual Issues |  |  |  |  |  |  |
| Appetite Disturbance |  |  |  |  |  |  |
| Irritability |  |  |  |  |  |  |
| Agitation |  |  |  |  |  |  |
| Sleep Disturbance |  |  |  |  |  |  |
| Hopelessness /Helplessness |  |  |  |  |  |  |

Current Clinical Information: Substance Abuse

MildModerateSevereAcuteChronicN/A

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Loss of Control of Dosage |  |  |  |  |  |  |
| Amnesic Episodes |  |  |  |  |  |  |
| Legal Problems |  |  |  |  |  |  |
| Alcohol Abuse |  |  |  |  |  |  |
| Opiate Abuse |  |  |  |  |  |  |
| Prescription Medication Abuse |  |  |  |  |  |  |
| Polysubstance Abuse |  |  |  |  |  |  |

Other Substance Abuse Please Specify:

Current Clinical Information: Personality Disorder

MildModerateSevereAcuteChronicN/A

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Oddness / Eccentricities |  |  |  |  |  |  |
| Oppositional |  |  |  |  |  |  |
| Disregard for Law |  |  |  |  |  |  |
| Recurring Self Injuries |  |  |  |  |  |  |
| Sense of Entitlement |  |  |  |  |  |  |
| Passive Aggressive |  |  |  |  |  |  |
| Dependency |  |  |  |  |  |  |

Other Personality Disorder (Enduring Traits of):

Response to current treatment:

Presenting Problems (Include Historical)

Select all that apply. Provide brief explanation.

|  |  |
| --- | --- |
| Self-Harm |  |
| Sexual Offense |  |
| Fire setting and / or property destruction |  |
| Runaway |  |
| Threats of Violence |  |
| Active Substance Use |  |
| Behavioral problems |  |
| Imminent risk of out-of-home placement |  |

Please provide details for any Presenting Problems listed above occurring within the last 180 days (six months):

What are the current stressors in the home environment?

Services Received Please select all that apply:

SelectWhereAdmission Discharge Number of

DateDateAdmits

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Inpatient Hospital |  |  |  |  |  |
| Residential Treatment Facility |  |  |  |  |  |
| Child Caring Institute |  |  |  |  |  |
| DJJ |  |  |  |  |  |
| DFCS |  |  |  |  |  |
| Juvenile Court |  |  |  |  |  |
| Regional Youth Detention Center |  |  |  |  |  |
| Youth Development Center |  |  |  |  |  |
| Crisis Stabilization Unit |  |  |  |  |  |
| Other |  |  |  |  |  |

Has the parent/guardian been informed about services provided by Community Service Board of Middle

Georgia and provided consent for this referral to be placed? ☐Yes ☐No

Is the parent accepting of support from Wraparound? ☐Yes ☐No

If 18 or older does youth accept support from Wraparound? ☐Yes ☐No

Do you have the following information: Diagnosis verification, Behavioral Health Assessment, CSU/PRTF discharge papers, Psychological, DR. Apt. Notes, CANS, and a copy of insurance cards? ☐Yes ☐No If so, please attach.

# Family History

Please use this page to provide a brief overview of family history and any information you would like us to be aware of up front.