

**Middle Georgia
Intensive Customized Care Coordination (IC3)**

Submit completed referral to hope@csbmg.com
Include CANS assessment and any supporting documentation.



Referring Party:	Contact:	Is the family aware and approving of referral?	Yes	No
Date of Referral:				
Youth Name:	Date of Birth:	Age:		
Race:	Language:	Gender:	Gender Identity:	
Insurance provider:	Insurance policy #:	Youth SSN (if available):		
Parent/Guardian Name:	Relationship to youth:	Duration of guardianship:		
Parent/Guardian Email:	Primary Phone #:			
Secondary contact person:	Relationship to youth:	Secondary contact #:		
Home address:	City/State/Zip:	County:		

Agencies currently involved with youth/family:

Services within last 6 months (180 days):

School:	Grade:	Inpatient hospital:	Dates:
Acute Crisis Stabilization Unit:		Crisis Unit:	Dates:
Residential Facility (PRTF):		PRTF:	Dates:
Group Home:		DFCS	
Dept of Juvenile Justice	Date of DJJ intake:	Court	
Outpatient behavioral/mental health:		DJJ	
Primary Care Physician:		YDC	Dates:
DFCS:		RYDC	Dates:

Current mental health diagnosis: Primary: _____ Dx Date: _____ Secondary _____ Date: _____

Medical diagnosis: _____ Date: _____ Date: _____

Current medications (include date prescribed): _____

Life functioning needs: (please select areas in which the youth demonstrates need for monitoring, action, or intervention)

- Family Living Situation Social Functioning Legal Sleep Recreational School Behavior

Past or current exposure to traumatic/adverse childhood experiences: (please select areas that apply)

- Sexual abuse Physical abuse Emotional abuse Neglect Witness to family violence Community violence
- School violence Disruption to caregiving/attachment losses Other: _____

Child/Behavioral Needs: (please select all areas in which the youth demonstrates need for monitoring, action, or intervention)

- Psychosis Attention/Concentration Impulsivity Depression Anxiety Substance abuse
- Attachment difficulties Anger control Other: _____

Presenting problems: (indicate concerns that apply to the youth)

- Suicidal thoughts Suicide attempts Homicidal thoughts Threats of violence Harm to others Harm to self
- Running Away Active substance use Imminent risk of out-of-home placement Other: _____

Indicate reason for referral: (include current challenges at home, school and in community)

Provide a brief history/background of the youth and family: (discuss information that would be important and beneficial to know)