|  |  |  |  |
| --- | --- | --- | --- |
| PROVIDER/ADDRESS/TELEPHONE:Staunton Clinic111 Hazel Lane, Suite 300Sewickley, PA 15143412-749-7330Fax: 412-749-7765 |  | [ ]  | **CHILD REFERRAL FORM**Blended Service Coordination/ Case Management Program |
| CONTACT PERSON: Lori Grubbs 412-749-7441 |  |  |  |

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| DATE: |       |  |  |  |       |  |       |  |       |

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| --- | --- | --- | --- | --- | --- |
| NAME: |       | Parent/Guardian: |       | M.A. ID #: |       |

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| ss#: |       | DOB: |       | AGE: |       | INSURANCE: | [ ]  VBH | [ ]  COUNTY | [ ]  MA | OTHER: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| ADDRESS: |       | PHONE: |       |

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| NEED FOR SERVICE:       |

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| --- | --- | --- | --- |
| REFERRAL SOURCE: |       | Phone: | Email: |

**1. DIAGNOSIS: (Please attach verification of diagnosis) Primary diagnosis cannot be:**  ID or Psychoactive Substance Abuse, Organic Brain Syndrome or V Code):

|  |  |  |  |
| --- | --- | --- | --- |
| Primary: |       | Secondary: |       |

**2. TREATMENT HISTORY: (Check all that apply and LIST HOSPITALIZATIONS ON BACK OF FORM)**

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | 6 or more days of Psychiatric Inpatient in 12 months | [ ]  | At risk of out-of-home placement without Blended Case Management |
| [ ]  | Currently receiving services by two or more human services agencies or public system such as Special Education, Children & Youth, Juvenile Justice Assigned Contact/Phone Number:Assigned Contact/Phone Number:Assigned Contact/Phone Number: |
| [ ]  | Children recommended for mental health services by County CASSP or Multi-Service Children’s Team |

**3. FUNCTIONING LEVEL: (Check at least one)**

|  |  |
| --- | --- |
| [ ]  | Individuals receiving BCM services as children and recommended and approved for continued services. |

**4. MEDICAL NECESSITY:**

|  |  |
| --- | --- |
| [ ]  | The individual is in need of BCM services as indicated through medical necessity criteria and in conjunction with clinical information and the professional judgment of the reviewer. |

I WISH TO BE CONSIDERED FOR THE BLENDED CASE MANAGEMENT PROGRAM.

Consumer’s Signature: Date:

Parent/Guardian Signature: Date:

Referral Source Signature: Date:

**\*\*\* Please include verification of diagnosis. Primary diagnosis cannot be:** ID or Psychoactive Substance Abuse, Organic Brain Syndrome or V Code):