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| PROVIDER/ADDRESS/TELEPHONE:  Staunton Clinic  111 Hazel Lane, Suite 300  Sewickley, PA 15143  412-749-7330  Fax: 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: |

|  |  |  |  |
| --- | --- | --- | --- |
| 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)**

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| --- | --- | --- | --- |
|  | 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):