CONSUMER DIRECT CARE NETWORK

Behavioral Health
REFERRAL FORM

Client Name: _____ **Date of Referral:** _____

DOB: _____ **SSN**: _____ **Gender:** _____

Grade: _____ **School:** _____ **Counselor:** _____

Person Making Referral: _____ **Contact Number:** _____

Parent Name: _____ **Parent Phone:** _____

Parent Address: _____

Parent Email: _____

Does youth have an IEP? **Yes / No**

Does youth receive other Mental or Developmental health services? **Yes / No**

Medical/Insurance Coverage: HMK Plus (Medicaid) HMK (CHIP) Insurance Private Pay/Sliding Fee

Consumer Direct Care Network Montana Behavioral Health (CDCN-MBH) is a mental health & developmental disabilities center providing mental health & developmental disabilities interventions to identified youth. There are separate costs associated with Mental Health services, some of which are covered by insurance plans. The CDCN-MBH team will work with families to verify coverage and/or assist with providing supports to Clients.

Referral Signatures

I certify that I am making this referral for CDCN-MBH services for the above Client due to concerns related to behavioral or emotional issues that may impact quality of life. I understand that this referral is for assessment and screening purposes only, and that admission into the CDCN-MBH program is contingent on the Client meeting clinical criteria for the program as outlined in Montana Administrative Rule. ***Parent/Legal Guardian MUST sign this form in order for a referral to be processed****.*

Person Referring Signature: _____

Parent/Legal Guardian Signature: _____

Referral Information:

Please provide a short description of concerns, including any concerns about mood, behavior, school attendance, etc. that are prompting this referral. What does the problem/challenging behavior look like for this particular Client? (Attach separate paper/documentation if needed) _____

_____

_____

How frequently does the behavior occur? _____

_____

When the behavior occurs, how long does it typically last? _____

_____

With whom does the behavior typically occur? _____

_____

_____

OFFICE USE ONLY: *Referral Received:* _____ *Assessment Scheduled:* _____ *Admitted to Program/Date:* _____

04321

Please provide any history of hospitalization, foster care, or group home placements _____

_____

_____

(For children under 3) Please provide a history of Part C intervention _____

_____

_____

Has your child received any of the following services?

Outpatient therapy (6 sessions over 60 days)	**Y**	**N**
Targeted Case management (last 60 days)	**Y**	**N**
Physician care or consultation (in the last 60 days)	**Y**	**N**
Documented crisis intervention (at least twice in 30 days)	**Y**	**N**

If any of the above were answered yes, when did these occur? _____

_____

_____

Please circle any symptoms that might be present:

Attention Difficulties:	Revved up/Cannot Slow Down	Jumpy	Poor or dangerous decision making	Impulsive/Does not think before acting	Cannot sit still for very long
	Fidgety, or has to fidget with objects	Inattentive, unable to focus on tasks	Seems like in a fog, can't pay attention	Doesn't seem to track information	Scattered or preoccupied
Behavioral Difficulties:	Defiant	Easily Loses Temper	Frequently Argues	Overreacts	Easily Annoyed
	Angry/Resentful	Frequently sleeps in class/home	Doesn't turn in schoolwork, even though capable	Disruptive in classroom/home	Interrupts constantly
	Blames others for mistakes or misbehavior	Manipulative	Leaves classroom/home without permission on a regular basis	Bullies/threatens others	Inconsiderate of other people's feelings
	Spiteful/Vindictive	Deliberately annoys others	Easily manipulated by others	Cries a lot	Often lies or cheats
Behavioral Outbursts:	Aggressive (physical)	Aggressive (verbal)	Disrespectful and rude toward adults/Peers	Has made homicidal threats	Overly persistent and cannot let an issue go

Mood Disturbances:	Reports insomnia	Withdraws from social interaction	Easily fatigued	Frequent complaints of aches and pains	Seems sad or depressed
	Anxious	Mood Swings	Low Self-Esteem	Significant weight gain or loss	Has made suicidal threats
	Nervous in new situations	Struggles with confidence	Often seems unhappy or tearful	Worries a lot	Hypercritical of self
Social/Emotional Challenges:	Picked on by others/bullied	Would rather be alone than with others	Difficulty with hygiene or grooming	Doesn't seem to pick up on social cues	Does not appear to have a positive peer group
Possible trauma-related symptoms:	Reports recurrent nightmares or intrusive thoughts	Easily startled or frightened	Has experienced a recent trauma/loss and having difficulty coping	Difficulty managing behaviors or mood	Reporting irrational fears

On a scale of 1 (least disruptive) to 5 (most disruptive), how would you rate the effect of the behavior on:

	Least		Moderate		Worst	
Client Academic Performance	**1**	**2**	**3**	**4**	**5**	**not sure**
Classroom/Home Management	**1**	**2**	**3**	**4**	**5**	**not sure**
Ability to seek and maintain appropriate friendships/family relationships	**1**	**2**	**3**	**4**	**5**	**not sure**
Client's Ability to Enjoy School/Home	**1**	**2**	**3**	**4**	**5**	**not sure**
Client's Ability to Engage in Community Activities	**1**	**2**	**3**	**4**	**5**	**not sure**
Ability to attend school regularly (include suspensions)	**1**	**2**	**3**	**4**	**5**	**not sure**
Client's Safety in the School/Home Environment	**1**	**2**	**3**	**4**	**5**	**not sure**
Respectful interactions within the School/Community/Home environment	**1**	**2**	**3**	**4**	**5**	**not sure**

Contact Information

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