



Better Morning ICC referral form

Please complete the following information to the best of your ability and provide the necessary supporting documentation. **Please note: Only electronic referrals will be accepted. The referral will only be considered complete with all of the fields being populated, the additional supplemental documents being provided, and the DBH HIPPA 3 Form signed by the legal guardian/parent.**

Referring Agency:

Date of Referral:

Referring Person:

Phone:

Email:

Referring Person's Supervisor:

Phone:

Email:

Please explain the reason for referral (current behavioral concerns, goal or expectations of wraparound):

A signed release must accompany all submitted referrals.

Pertinent clinical documentation (At least 2 items from the list below)

Psycho-social report

Latest IEP

Latest court order, court report, initial petition, and any court related documents

Most recent psychiatric/psychological evaluation

Most recent psycho-educational assessment

Core Service Agency Diagnostic and Assessment

If child or youth in PRTF, please include most recent treatment plan.

Youth Information

Name: _____ SSN: _____ Date of Birth: _____ Age: _____

Race/Ethnicity: _____ Sex: _____

Religion: _____ Preferred Language: _____ ICAMS # : _____ CAFAS/PECFAS Score: _____

Medicaid ID # : _____

Additional Insurance & ID # :



Physical custodian of child: Parent CFSA DYRS Other _____

Child's Legal Guardian: Individual's name: _____

Address: _____

Phone #: _____ Email: _____

Has there been a Termination of Parental Rights (TPR)? Y N If yes, with? _____

Is the child's mother involve in his/her life? Y N Is the child's father involve in his/her life? Y N

Current housing location of child: Parent/Guardian Institution Hospital PRTF RTC

Group home/Congregate Care Facility Foster home Shelter

Address: _____ Phone#: _____

When was the youth first engaged in a system (date)? _____ Which Agency? _____

How long ago was the youth removed from their home? _____

Initial Screening – Please check all that apply

- The Youth has behavioral/emotional symptoms that suggest a diagnosable emotional disorder.
- The youth has a significant difficulty that has lasted or is expected to last for a year or more due to her/his serious emotional disturbance.
- The youth needs, has received or has requested services or support from two or more child serving systems.
- The youth is at risk of out-of-home placement or out-of-school placement due to the impact of the serious emotional and/or behavioral disturbance.
- The youth and her/his parent, guardian, or foster parent reside in a county served by the District of Columbia Systems of Care Initiative.
- The family volunteers for this service and agrees to participate actively.

Caregiver / Family Factors

- | | |
|---|---|
| <input type="checkbox"/> Chronic physical illness in family | <input type="checkbox"/> Parental incarceration |
| <input type="checkbox"/> Family history of mental illness, psychiatric hospitalization or substance abuse | <input type="checkbox"/> History of domestic violence |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Poverty |
| <input type="checkbox"/> Victim of physical abuse (other than youth) | <input type="checkbox"/> Other children in foster care |
| <input type="checkbox"/> Victim of sexual abuse (other than youth) | <input type="checkbox"/> Youth exposed to substance abuse in the home |

Youth Risk Factors (please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Runaway / leaving home without permission | <input type="checkbox"/> Chronic illness |
| <input type="checkbox"/> Withdrawal from family, social activities | <input type="checkbox"/> Self-abusive behavior |
| <input type="checkbox"/> Recent dramatic changes in eating habits, sleep pattern or body weight | <input type="checkbox"/> Repeated incidents of lying, stealing, property destruction |

- | | |
|--|--|
| <input type="checkbox"/> Age or developmentally inappropriate bed-wetting or soiling | <input type="checkbox"/> Physical aggression toward authority figures, family members, peers |
| <input type="checkbox"/> Sexually reactive behavior | <input type="checkbox"/> Intentionally hurts others |
| <input type="checkbox"/> Perpetrator of sexual abuse | <input type="checkbox"/> Intentionally hurts animals |
| <input type="checkbox"/> Victim of sexual abuse | <input type="checkbox"/> Sets fires |
| <input type="checkbox"/> Victim of physical abuse | <input type="checkbox"/> Involvement in criminal activity |
| <input type="checkbox"/> Use or abuse of alcohol or drugs | <input type="checkbox"/> Declining school grades, truancy, poor attendance |
| <input type="checkbox"/> Attempted suicide or suicidal thoughts | <input type="checkbox"/> School suspensions / expulsions |
| <input type="checkbox"/> Hallucinations – aural, visual or tactile | <input type="checkbox"/> Developmental delays |
| <input type="checkbox"/> History of inpatient psychiatric hospitalization(s) | <input type="checkbox"/> History of neglect |
| <input type="checkbox"/> History of placement disruptions | <input type="checkbox"/> Traumatic loss of family/friend |
| <input type="checkbox"/> Witness to violence | <input type="checkbox"/> History of trauma |

Youth Diagnosis Information	
Axis I Diagnosis (Clinical Disorders):	
Axis II Diagnosis (Personality Disorders, MRDD):	
Axis III Diagnosis (General Medical Conditions):	
Axis IV Diagnosis (Psychosocial & Environmental Problems):	
<input type="checkbox"/> Problems with primary support group	<input type="checkbox"/> Economic problems
<input type="checkbox"/> Problems related to the social environment	<input type="checkbox"/> Problems with access to health care services
<input type="checkbox"/> Educational problems	<input type="checkbox"/> Occupational problems
<input type="checkbox"/> Other psychosocial and environmental problems	<input type="checkbox"/> Housing problems
<input type="checkbox"/> Problems related to interaction with the legal system	
Axis V Diagnosis: Global Assessment of Functioning (GAF):	

Who made the above diagnosis? _____ Date: _____
 Child Psychiatrist General Psychiatrist Child Psychologist General Psychologist Licensed Clinical Social Worker

Primary Care Physician Other (specify): _____

List prescribed psychotropic medication(s) by psychiatrist or PCP (please list): _____

Primary Care Physician (PCP): Name _____ Phone #: _____

List any current and chronic medical conditions: _____

PRTF (Psychiatric Residential Treatment Facility) or Residential Treatment Center (RTC) History:

Has this youth been in PRTF or RTC before? Y N How many PRTFs? _____ How many RTCs? _____

How long has the youth been in PRTF? _____ Years _____ Months

How long has the youth been in RTC? _____ Years _____ Months

Most recent PRTF or RTC Name: _____ Full Address: _____

Therapist Name: _____ Phone: _____ Phone (2): _____

Do you believe this child is benefitting from the services received in PRTF? Y N

Do you believe this child is benefitting from the services received in RTC? Y N

Agency Involvement

Check all agencies involved with the child: APRA CFSA CSS DCPS DBH DYRS
 other _____

Current or last school last attended: _____ Grade: _____ Special Ed? Y N

Current IEP? Y; Please include with referral N

Juvenile Legal Status: Pre-disposition Probation Committed None

Child Welfare Status: Involved Committed None

Court Involvement? Y N Judge's Name(s): _____

Within the last year, please answer the following questions regarding the youth:

1. Number of abscondences: _____
2. Number of placements (please note hospitalizations do not count as placements): _____
3. Number of charges within the juvenile or adult systems: _____ Current charges: _____
4. Days of Truancy: _____ Has referral for habitual truancy been completed. If so, when? _____
5. Number of Hospitalizations: _____ Last Hospitalizations and where:

Specify mental health services/interventions the youth received in the past year in the chart below:

Mental Health Service	Name	Phone # and/or email address	Core Service Agency (Identify Clinical Home) Company and frequency of service delivery
<input type="checkbox"/> Individual therapy			
<input type="checkbox"/> Family Therapy			
<input type="checkbox"/> Group Therapy			
<input type="checkbox"/> Medication Management			
<input type="checkbox"/> Community Support (CSW)			
<input type="checkbox"/> Community Based Intervention: CBI, MST & FFT (Please circle level)			
<input type="checkbox"/> Therapeutic Afterschool Program			
<input type="checkbox"/> School Based Mental Health Services			
<input type="checkbox"/> Hospitalization			
<input type="checkbox"/> Substance Use/Abuse Treatment			
<input type="checkbox"/> Other			

Youth's Siblings, Family and Other Household Members

Name	Gender	Date of Birth/Age	Relationship to Youth	School Grade	Lives Where?

Team Information

Has a team including the youth and family been meeting regularly to address the needs of the youth? Y N

If so, please provide the date of the last meeting. _____

Facilitator: Name: _____ Agency: _____ Phone: ____

If not, what is the reason for this? _____

Team Members: *Parents, foster parents, siblings, family's natural support network (e.g., extended family, neighbors, faith community, coaches, etc.), Peer/Family Support Partner, CSA/Mental Health provider, CFSA, DYRS, CSS, DCPS, GAL, parent's attorneys, etc. Please include all team members and their contact information.*

Name	Relation to Youth	Agency	Phone Number(s)	Email Address

Strengths

Describe the **youth and families' strengths** that will assist in keeping the youth at home and within the community; or what strengths will assist in the successful return of the youth from the community?

