CHILDREN'S HOME
OF JEFFERSON COUNTY
A Legacy of Compassion Since 1859

Referral Packet

To: Persons/Agencies initiating placement of a child into the Therapeutic Crisis Respite Program (TCRP).

From: Intake Department

The following information will be required upon admission and will be reviewed and collected by the Care Coordinator:

- ☐ Signed Releases (signed by the parent/legal guardian)
- ☐ Immunization Records
- ☐ Disability Slip (if applicable)
- ☐ 15 Day Supply for all Medications (or 15 Day Prescription)
- ☐ Recent Psychological/Psychiatric Evaluation (if applicable)
- ☐ Recent Safety Plans (if applicable)

Thank you for your cooperation.

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ADMISSION/REFERRAL EVALUATION FORM

DATE OF REFERRAL: **DATE OF ADMISSION:**

REFERRAL CONTACT INFORMATION

NAME: ORGANIZATION: ☐N/A

NUMBER:

EMAIL:

BEST TIME TO CONTACT:

RELATIONSHIP TO YOUTH:

Demographic Information

CHILD'S NAME: (Last) (First) (M)

Nickname/Preferred Name:

DATE OF BIRTH: GENDER: RACE:

LAST KNOWN ADDRESS:

New, York (Zip)

COUNTY:

Insurance Information

Insurance Company:

Policy Number: Policy Holder Name:

If Medicaid, please include Sequence Number :

Note: Please provide a copy of the the insurance card is possible.

Parent/Caretaker/Guardian Information

PRIMARY CARETAKER:

RELATIONSHIP TO YOUTH:

CONTACT INFORMATION:

Number:

Email:

Address: ☐ Same as youth

New York,

Best time to Contact:

ALTERNATIVE/SECONDARY CARETAKER (if applicable):

RELATIONSHIP TO YOUTH:

CONTACT INFORMATION:

Number:

Email:

Address: ☐ Same as youth

New York,

Best time to Contact:

Presenting Problems/Concerns

Why are your seeking TCR services:

HAS CHILD DISPLAYED ANY OF THE FOLLOWING BEHAVIORS IN THE LAST SIX MONTHS:

☐ Assault ☐ AWOL ☐ Drug/Acohol Use ☐ Trauma ☐ Theft
☐ Suicide Attempt ☐ Fire Setting ☐ Aggression ☐ Brain Injury ☐ Sexual Offense
☐ Indiscriminate Sexualized Behaviors ☐ Cruelty Toward Animals ☐ Development Disability
☐ History of Out of Home Placement ☐ Other:

Please explain:

Medical Information

ALLERGIES: ADDICTIONS:
ACTIVE MEDICAL CONDITIONS:
CURRENT DENTAL OR EYE CONCERNS:
PRIMARY CARE PROVIDER: PHONE:

CURRENT MEDICATIONS:

NAME	DOSAGE	FREQUENCY	START DATE

(Must have a 15 day supply or 15 day prescription)

PSYCHIATRIC DIAGNOSIS (list all):

PSYCHIATRIST: PHONE:

DATE OF LAST EVALUATION:_____

MAY BE COMPLETED FOLLOWING ADMISSION

Current Service Providers (if applicable)

NAME	AGENCY	TELEPHONE NUMBER	START DATE

Legal Information

Current Orders of Protection: ☐ Yes ☐ No ☐ Unknown
Is anyone not allowed to have contact with youth (include name if yes):
Legal Status (if applicable): ☐ JD ☐ PINS ☐ Article 10 ☐ Other ☐ Unknown ☐ Other:

Educational Information

CURRENT/LAST SCHOOL ATTENDED:

CONTACT PERSON: GRADE LEVEL:

IEP: ☐ YES ☐ NO CLASSIFICATION:

I.Q: ☐ Unknown

If possible, please provide a copy of any academic testing results. When possible, CHJC will work with current school district to ensure continuity of education for the youth.