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Placement Referral

Completed By: _____ **Date Completed:** _____

Child's Name: _____ **DOB:** _____ **Gender:** _____
Guardian Name: _____ **TCM Agency:** _____ **TCM Name:** _____
Where is child currently placed? _____ **CDDO:** _____ **Race** _____
Current Address/Location of Child: _____ **MCO:** _____
TCM email: _____ **Care Coordinator:** _____

Geographic Preference: _____
Date Placement is Needed: _____ **Length of Stay needed:** _____
Guardian Name(s): _____
Guardian Address (street, city): _____
Referred by: _____ **IDD Waiver Tier and Waitlist Status :** _____

Reason for needing Children Residential/ Respite or both? : _____

1) New Placement Should Have:

2) New Placement Should NOT Have:

3) Child Would Like New Placement To Have:

4) Child's Hobbies and Interests:

5) Interventions (what works, what to avoid)

6) Strengths Based Description of Child:

CLIENT'S STRENGTHS **(All fields required)**

Strength	Information Source	Explanation
		.
		.

VISITATION **(Who child has visitation or visitation restrictions with, including "No Visitation Allowed") (All fields required)**

Person	Relationship to Child	Restrictions	Frequency of Visit	Court Ordered

SIBLING INFORMATION **(All fields required)**

Name	DOB	Gender	Race	Explanation:

PLACEMENT HISTORY- Support Heathy Connections

Name of Placement	Relationship	Begin Date	End Date	Reason for Move	Behaviors

CLIENT'S PROFILE (All applicable conditions are to have BeginDate and Frequency or Risk filled in)

Condition/Diagnosis:	**Begin Date**	**Notification Date**	**Date of Last Occurance**	**End Date**	**Frequency, Risk, Explanation**
Aggression, physical, mobility					
Theft					
Runs/Leaves/Returns/Elopes					
Temper Tantrums					
Defies Authority at School					
Defies Authority at Home					
Self Injurious Behavior					

Aggression, verbal					
Sexually Acts Out					
Profanity					
Vandalism / Property Destruction/Theft					
Medical Conditions/Seizures/Nurse Care					
Victim of Sexual Abuse					
Communication:					
Encopresis, Enuroesis					

MEDICAL

Height: __ft __in **Weight:** lbs

Current Medical Doctor: _____ **City:** _____ **State:** _____

Current Dentist: _____ **City:** _____ **State:** _____

Current Eye Doctor: _____ **City:** _____ **State:** _____

Medical/Health Concerns/Medical Diagnosis, if any: _____

Allergies: _____

Medical Appointments Upcoming - Significant:

Appointment Type	When	Where	With Whom	Notes

MEDICATIONS (All current medications prescribed for child) (Dosage and Frequency required)

Medication	Dosage	Frequency	Prescribed For	Prescribed By	Date Began

MENTAL HEALTH

Current Psychiatrist: _____ **City:** _____ **State:** _____

Mental Health Diagnosis:

_____

_____

_____

_____

_____

_____

Therapist Name: _____ **Therapist Agency:** _____

SED with Community Based Services?: _____

Mental Appointments Upcoming - Frequency:

Appointment Type	When	Where	With Whom	Notes

HCBS IDD Waiver SERVICES

Has child been diagnosed IDD? _____

Does the child have access to HCBS IDD Waiver?: _____

If yes, what tier level?:: _____

Does the child receive any social security funding? _____

Who is the Payee? _____

SCHOOL INFORMATION

Current School: _____ **Grade:** _____

Special Education Type: _____ **Date of Last IEP:** _____

School Issues (including frequency and severity of behaviors), supports such as para, and 18-21progamming :

_____

_____

. **Needs GED?:** _____

COURT INVOLVEMENT

Is there a current "No Run" order?: _____

Are there any pending criminal charges?: _____

If yes, please list pending charges:

_____

_____

Does youth need to complete community service hours?: _____

If yes, how many?: _____

List all court orders specific to placement:

_____

SAFETY PLAN INFORMATION

Does this child have a previous maintenance or safety plan on file?: _____

Does this child need a maintenance or safety plan prior to a new placement?: _____

Has this placement referral been reviewed for accuracy?: _____

PREVENTATIVE MEASURES (Preventative Measure and How Long child has known Person are required)
List 5 Connections to this child outside of the child's family residence.

Name a Person who had a Connection to the child	Relationship	How Long	Explanation
			.

Choice Options (specify choice requirements or specific accomidations to support the child : ie, private room, alarms for safety, sharps, limits

CHOICE	Required	Preferred	Notes

ASSESSMENTS Additional Documentation Available

Assessement Type	Yes/No	Completed Date	Assessment Value	Notes
PCSP				
POC				
IEP				
Behavior Plan				
Tracking Frequency & Severity documentation				
Releases for sharing information				
Psychological Evaluations				
Other				

Signature of person completing referral

Relationship to client

Date