CASE REFERRAL FORM

MAP TEAM:_____CASE # _____ MAP TEAM # _____

Referral Identifying Information

Name:_____ DOB:_____ Age:_____

SS#:__xxx-xx-_____ Sex:_____ Race: _____

County of Residence: _____ Grade:_____

PARENT/LEGAL GUARDIAN INFORMATION:

Parent/Legal Guardian Name:_____ Relationship:_____

Phone:_____ Address:_____

Parent/Legal Guardian Name:_____ Relationship:_____

Phone:_____ Address:_____

Financial Resource Potential (payment source): Medicaid Eligible? Yes No If yes, provide #

Referral Source: _____ Insurance #: _____

Mental Health Information

Diagnosis: (A provisional diagnosis, made by the Masters' level mental health representative on the team, may be included based on symptoms/behaviors listed below.)

List Diagnosis:

Primary: _____

Secondary: _____

If diagnosis is not known, please list behaviors (be specific) that would indicate that this child/youth has emotional/behavioral problems*: _____

_____

TERMS:

***Emotional/Behavioral problems, examples but not limited to: Suicidal and/or Homicidal Ideations, Anxiety, Depression, Destructive, Defiant**

***Out-of-Home Placement, examples but not limited to: Acute Psychiatric Placement, Temporary CPS Placement, Short-Term Crisis Stabilization, Clinical Care, Group Home. When a child/youth is placed outside of their current living situation overnight.**

***Environmental Conditions, examples but not limited to: Homelessness, Utilities disconnected or Disconnection Notice of Utilities, Lack of Basic Needs**

***At-Risk, examples but not limited to: Imminent placement at Alternative School, Victim of Abuse and/or Neglect, Homicidal and/or Suicidal**

Key:
**** See Terms***

Additional MAP Team Case Referral Information

Current living arrangements (biological family, foster family, etc.) for the child/youth:

_____

All known previous placements (where/timeframe, if known) for the child/youth:

_____

_____

_____

Is the child/youth currently in CPS custody? Yes No

When did the child/youth start receiving CPS services? If receiving services, state the reason:

_____

_____

_____

What is the longest period the child/youth stayed in one placement and which placement was it?

_____

Has a psychological evaluation been done within the last six months and if so, what were the recommendations? _____

_____

Is the child/youth currently in a facility? Yes No

Discharged facility within past 12 months? Yes No Month/Year _____

If you answered yes to either of these questions, what were the recommendations?

_____

Provide some insight as to what has led to so many unsuccessful placements for this child/youth:

_____

_____

_____

_____

_____

_____

As a MANDATED REPORTER, if you SUSPECT that the youth/child is being abused and/or neglected, it is YOUR responsibility to report it to the Child Abuse Hotline at: 1-800-222-8000 or online at: https://reportabuse.mdcps.ms.gov

Placement Risk Information

How is this child/youth considered to be at immediate risk for an out-of-home placement*?

_____

_____

_____

_____

What behaviors and/or environmental conditions* exist for the child/family that place this child/youth at-risk* for an out-of-home placement?

_____

_____

_____

_____

Why is this child/youth being referred to the MAP Team?

_____

_____

_____

_____

MAP Team Drug and/or Alcohol Assessment Checklist

Is there any current/history of usage of alcohol/drugs/tobacco by child/youth and is there any treatment history for such? Yes / No / Unknown

_____

Is there any family history of alcohol/drug usage and/or treatment for the parent/legal guardian? Yes / No / Unknown

_____

Was there any known alcohol/drug usage by mother during pregnancy?

Yes / No / Unknown _____

Other comments regarding any part that drugs/alcohol may have played in this child's at-risk status:

_____

_____

_____

MAP TEAM **STRENGTHS ASSESSMENT**	Child's Name _____ Review Date _____
Strengths of the Child/Family *(what child/family likes to do/is able to do)*	**Needs of the Child/Family** *(what child/family needs to reach their goals)*

MAP TEAM TEAM ASSESSMENT	Child's Name _____ Review Date _____

SOCIAL HISTORY

Does child/youth have siblings? ___ Yes ___ No

If yes, please include their gender and ages:

_____

_____

If yes, do the siblings live in the same household as the child/youth being referred?
___ Yes ___ No

EDUCATIONAL HISTORY

Name of school child/youth attends: _____

If child/youth is not currently in school, name of last school attended, and highest grade completed: _____

Is child/youth in Special Education? ___ Yes ___ No
If yes, what SPED ruling does child/youth have? _____

_____

Describe difficulties child/youth is having in school:

_____

_____

_____

MENTAL HEALTH HISTORY

Is child/youth currently receiving mental health services? ___ Yes ___ No

If yes, what services are the child receiving? ___ Outpatient Therapy ___ Case Management
___ Day Treatment ____ Physician's Services ___ Other

If yes, what agency is providing these services? _____

Has child been hospitalized for psychiatric treatment? ___ Yes ___ No

If child has been hospitalized for psychiatric treatment, list hospitalizations for the past year (if known). _____

_____

_____

(Continued on next page)

MAP TEAM TEAM ASSESSMENT (page 2)	Child's Name _____ Review Date _____

JUVENILE JUSTICE

Is this child/youth involved in the juvenile justice system? ___ Yes ___ No

If yes, what is this child/youth's involvement with the juvenile justice system?

_____

_____

COMMUNITY RESOURCES

What resources have you received or identified for services (i.e. assistance from local churches, human resource agencies, Families First Resource Centers, Big Brothers/Big Sisters, etc.)?

_____

_____

_____

_____

_____

Have these resources been helpful? ___ Yes ___ No

ADDITIONAL INFORMATION

Additional information provided by MAP Team members about this child/youth/family:

_____

_____

_____

_____

_____

_____

_____

_____

_____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

In order to serve you better presented is:

I, _____, of _____
(Parent /Guardian) *(Parent /Guardian Address)*
authorize the Multi-Disciplinary Assessment and Planning (MAP) Team to exchange information regarding my family and _____
(Name of child/youth)

with professional representatives from, but not restricted to, Department of Human Services, Child Protective Services (CPS), Department of Health, Schools, Juvenile Court Services, Truancy Officers, Mental Health and other community professionals for the following reasons: **Purpose and Need for Disclosure** (to work as teams to help prevent out-of-home placement for the child/youth)

_____

_____

It has been explained to me that the MAP Team consists of a professional representative from the Division of Social Services, Child Protective Services, Schools, Juvenile Court Service, and representatives from other human service agencies that serve the needs of children/youth and their families (Youth Services, Family Services, etc.). Also invited to participate in a MAP Team are any other appropriate community professional who are closely involved with the child/youth (teachers, principals, counselors, etc.). **The purpose of the MAP Team is to work together to provide information to help serve the child/youth's needs in the community with accommodating resources and to ensure the child/youth is resilient in some form, share information and gather resources in order to develop specific recommendations to best serve the needs of the child/youth.**

This consent will expire on: _____
(One year from today's date)

I further acknowledge that the information to be released was explained to me and this consent is given of my own free will. I also direct and request that professional representatives accept a photocopy of this release as a valid authorization to release such information. The parent/legal guardian or youth (if 18 and older) has the right to cancel/withdraw their consent at any time.

_____ _____
Youth Signature ***(only if 18 and older)*** Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date