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#### Referral for Dane County Youth Connect Program

**Dane County Department of Human Services-Behavioral Health Division**

Youth Crisis Stabilization Services Face Sheet

Submit with Referral to: YouthConnect@countyofdane.com

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| Date: | Click or tap to enter a date. |
| Client Legal Name: | Click or tap here to enter text. | Preferred Name: | Click or tap here to enter text. |
| SSN:  | Click or tap here to enter text. | DOB: | Click or tap to enter a date. | Gender Identity:  | Choose an item. |
| Address: | Click or tap here to enter text. | Phone: | Click or tap here to enter text. |
| Parent/Guardian Name: | Click or tap here to enter text. | Phone: | Click or tap here to enter text. |
| Address (if different): | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
| Person Completing Referral:  | Click or tap here to enter text. | Contact Information: | Click or tap here to enter text. |
| Other Sources of Information: | Click or tap here to enter text. |
|  |  |  |
| Insurance:  | [ ]  None | [ ]  Medicaid/BadgerCare | [ ]  Private/HMO |
| Policy/Subscriber Number #: | Click or tap here to enter text. |
| Current School: | Click or tap here to enter text. | [ ]  IEP | [ ]  504 |
| Primary Contact: | Click or tap here to enter text. | Phone/Email: | Click or tap here to enter text. |
| Is Youth Currently Hospitalized: | [ ]  Yes | [ ]  No | Admission Date: | Click or tap to enter a date. |
| Pending Discharge Date:Click or tap to enter a date. | Hospital Name:Click or tap here to enter text. |
| Social Worker Name / Contact Information: | Click or tap here to enter text. |
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| Current Legal systems or any mandated services (Check all that apply): |
| [ ]  CPS | [ ]  Chapter 51 | [ ]  Treatment/Diversion  | [ ]  N/A |
| Social Worker Name / Contact Information: | Click or tap here to enter text. |
| **Immediate Supports Needed/Identified (by youth/family):** | [ ]  Psychiatry | [ ]  Psychological Evaluation |
| [ ]  Crisis Planning/Intervention | [ ]  Family/Parent Peer Support | [ ]  MH System Navigation/Coordination |
| [ ]  Therapist | [ ]  Discharge Planning | [ ]  Respite  | [ ]  Other | Click or tap here to enter text. |
| Current Natural & Community Supports: |  |
| Name/Agency: | Click or tap here to enter text. | Relationship: | Click or tap here to enter text. | Contact Info: | Click or tap here to enter text. |
| Name/Agency: | Click or tap here to enter text. | Relationship: | Click or tap here to enter text. | Contact Info: | Click or tap here to enter text. |
| Name/Agency: | Click or tap here to enter text. | Relationship: | Click or tap here to enter text. | Contact Info: | Click or tap here to enter text. |
| **Treatment Providers** |
| Primary Care | Click or tap here to enter text. | Contact Info: | Click or tap here to enter text. |
| Psychiatrist/Prescriber | Click or tap here to enter text. | Contact Info: | Click or tap here to enter text. |
| Is the youth currently working with a therapist? | [ ]  Yes | [ ]  No |  |
| Name |  | Contact Info: |  |
| Is the youth currently enrolled in:  | CCS: [ ]  Yes | [ ]  No  | CLTS: [ ]  Yes | [ ]  No | Other:Click or tap here to enter text. |
| If Yes, Name & Contact Info: | Click or tap here to enter text. |
| Has the applicant applied for any other support services/programs with pending eligibility determination? |
| [ ]  Yes | [ ]  No | If so, specify:  | Click or tap here to enter text. |
| Referral Status: | Click or tap here to enter text. |
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| **Mental Health and/or Substance Use Concerns** |
| Diagnoses | Click or tap here to enter text. |
| Diagnosing Doctor/Medical Professional  | Click or tap here to enter text. |
| Contact Info: | Click or tap here to enter text. | If none is help needed to seek a diagnosis?  | [ ]  Yes | [ ]  No |
| Please provide the following information, including dates:  |
| ER visits, psychiatric evaluation, or psychiatric hospitalizations in past 6 months: |
| Dates: Click or tap here to enter text. | Reason: | Click or tap here to enter text. |
| Dates: Click or tap here to enter text. | Reason: | Click or tap here to enter text. |
| Jail or Detention Stays: [ ]  Yes | [ ]  No | Date/Type: Click or tap here to enter text. |
| Recent Contact with law enforcement: [ ]  Yes | [ ]  No | Dates/Reason: Click or tap here to enter text. |
| In the past 12 months has the youth exhibited any of the following? |
| [ ]  Psychosis: Serious mental illness with delusions, hallucinations, and / or lost contact with reality |
| [ ]  Suicidality: Suicide attempt in past 12 months or significant suicidal ideation or plan in past month |
| [ ]  Violence: Life threatening acts  |
| If yes, please describe: | Click or tap here to enter text. |
| Additional Youth or Family Stressors/Needs: |
| [ ]  Parent referral for MH/SU Services  | [ ]  Economic |
| [ ]  Language/Cultural barriers to treatment services | [ ]  Housing |
| [ ]  Benefits counseling/application assistance  | [ ]  Transportation |
| [ ]  School Supports/Advocacy |
| Other relevant information: Click or tap here to enter text. |
| Primary Language: Click or tap here to enter text. |
| **Eligibility Determination:** |
| Review Date: Click or tap to enter a date. | [ ]  Yes | [ ]  No | YCS Initials: Click or tap here to enter text. |
| Follow up Notes: | Click or tap here to enter text. |