**Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

🞏 Male 🞏 Female **SSN: - -**

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Living Arrangement:** | Where is the student currently living? | | |
| **Legal Custodian:**  **Name, Address, Phone, Email**  **(Best way to contact)** |  | **Parent:**  **Name, Address, Phone, Email**  **(Best way to contact)** |  |
| **Case Responsible Agency:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Case Responsible Professional (required): | | |
| Email Address: | | |
| Address: | | |
| Office Number/Cell/ Fax Number: | | |
| School Placement | Name: Phone #: IEP □ Yes □ No | | |
| Funding Source | Name: Insurance/Medicaid #: MCO record # | | |
| MCO:  Care Coordinator: | Name:  Phone # Email Address: | | |
| Primary Care Physician: | Name: Practice: | | |
| Psychiatrist | Name: Practice | | |
| DJJ Court Counselor  [ ] none | Name: Phone #: Email: | | |

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| --- | --- | --- | --- |
| **CURRENT STATUS** | | | |
| **I. CURRENT BEHAVIORS/PRESENTING PROBLEMS AND REASON FOR REFERRAL** | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
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| **A. Diagnoses**  **By Whom (required)?**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **What Date?**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Axis I: Indicate which is Primary (R) & Additional (A) | | |
|  | | |
|  | | |
|  | | |
|  | | |
| **B. Medications**  **Prescriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Medication: List all current medications** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Is the student compliant with medications? | | | |

**STUDENT NAME: RECORD NUMBER:**

|  |
| --- |
| **II. CURRENT STRESSORS** (Please check those that apply and describe in related sections) |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Legal Problems: | □ Yes | □ No | Physical Assault: | □ Yes | □ No | Addiction: | □ Yes | □ No |
| Medical Problems: | □ Yes | □ No | Relationship Problems: | □ Yes | □ No | Abuse History: | □ Yes | □ No |
| Sexual Assault/ Rape: | □ Yes | □ No | Separation/Loss: | □ Yes | □ No | Other: | □ Yes | □ No |

* (Required) Family has been notified and agrees to the referral

**Please attach most recent CCA**