Name: _____ Grade: _____Resident District _____

Minnewaska W.I.N.(What I Need) Academy Mental Health Services

Day Treatment & Intensive Outpatient

Referral Form

SECTION I: CHILD INFORMATION

Child's Name: _____Child's DOB ____/____/____ age: ____

Current Grade: _____ Home District: _____

Child's Social Security Number: _____

Gender: Male □ Female □

Current Living Situation:

Two-parent biological family □ One-parent biological family □
Two-parent adoptive family □ One-parent adoptive family □
Foster Care □ Therapeutic Foster Care □ Group Home □
Kinship Foster Care □ Relatives Home □
Psychiatric Inpatient Care □ Crisis Residence □ Shelter Care □
Day Treatment Program □ Residential Treatment Center □
Juvenile facility □ Other (specific) _____

SECTION II: REFERRAL SOURCE IDENTIFICATION

Date of Referral ___ / ___ / _____

Organization/Program Name: _____

Referral Organization Affiliation:

Mental Health □ Juvenile Justice □ Caregiver Family □
Social Services □ MR/Dev. Disabilities □ Education □ Court □ Medical □
Substance Abuse □ Child-Care Agency □ Community Agency □
Other (please describe) □ _____
Name of Person Making Referral: _____
Phone #: _____
Address: _____Town: _____
Zip: _____
Fax: _____

E-Mail: _____

SECTION III: FAMILY INFORMATION

Parent/Guardian Name: _____
Address: _____ City: _____
Zip Code:_____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Parent/Guardian Name: _____
Address: _____ City: _____
Zip Code:_____
Home Phone: _____ Cell Phone: _____
Work Phone: _____

Name: _____ Grade: _____Resident District _____

Primary language of family spoken at home:
English □ Spanish □ American Sign Language □ Other, Please Specify □_____
Race/Ethnic Identity:
White □ Black/African American □ Mexican, Mex-Am, Chicano □ Dominican □
Asian/Pacific Islander □ Puerto Rican □ Central American □
American Indian □ Cuban □ Other _____□
Significant cultural identity (specify) _____

Custody Status:
Two biological parents OR one biological parent and one step-parent □
Biological mother only □ Biological father only □ Relatives □
Adoptive parent(s) □ Foster parent(s) □ Friends (adult friend) □
State Guardianship □ Other (specify) _____

Family History	**Yes**	**No**	**Unknown**
Is there a history of domestic violence/spousal abuse in child's biological family?	□	□	□
Is there a history of mental illness in child's biological family?	□	□	□
Is there a history of substance abuse in child's biological family?	□	□	□
Does child's current family experience domestic violence/spousal abuse?	□	□	□
Does child's current parent/caretaker have mental illness?	□	□	□
Does child current parent/caretaker have substance abuse issues?	□	□	□

SECTION IV: INSURANCE INFORMATION
Type of health coverage
□ No insurance
□ Medicaid ID # _____
□ Application Pending □ Ineligible
□ Medicaid Managed Care Provider _____
ID # _____
□ Private, third party coverage _____
□ Other, identify _____

SECTION V: CHILD'S INFORMATION
Does child meet eligibility criteria for Serious Emotional Disturbance YES □ NO □
DSM-IV Diagnosis, if known (Please write diagnosis)

_____

_____

_____

_____

Date of Diagnostic Evaluation _____ Person Making Diagnosis_____

IQ Score (if known): Verbal _____ Performance _____ Full Scale _____ Test Date _____

Psychiatric Hospitalization History (please provide as much information that is known):

MINNEWASKA MENTAL HEALTH SERVICES INTENSIVE OUTPATIENT & DAY TREATMENT REFERRAL

Name: _____ Grade: _____Resident District _____

Number of previous hospitalizations: _____ Check if unknown □
Please list all hospitalizations (if known):
Name of Hospital Admission Date Discharge Date # Days Hospitalized

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Medication for Mental Health issues: Yes □ No □ Unknown □
If yes, list current medication(s) _____

Trauma History	Yes	No	Unknown
Has child ever been physically abused?	□	□	□
Has child experienced emotional abuse?	□	□	□
Has child ever been sexually abused?	□	□	□

Referral Concerns

Screener should consider a child's age, developmental and intellectual level and overall functioning in identifying problems. Check the 2nd column if the problem has been observed within the last month. Check the 3rd column if the problem has ever been observed. Both columns can be checked or left blank.

CHILD'S PROBLEMS	In last month	Ever
1. Excessive irritability		
2. Overly sensitive to environment (noise, touch) which causes distress		
3. Excessive sadness, crying, withdrawal		
4. Excessive fears or worries, difficulty separating from parents, school refusal		
5. Recurrent intrusive thoughts or senseless repetitive behaviors, such as hand washing, lock checking, organizing objects		
6. Suicidal thoughts, threats, gestures or attempts		
7. Hallucinations (sees or hears things that aren't there), delusions (has strong beliefs which have no basis in reality)		
8. Difficulty in concentration		
9. Irregular or problematic sleep patterns		
10. Many nightmares		
11. Irregular or problematic eating/appetite patterns		
12. Problems in activity patterns (over-active or under-active)		
13. Injures self, e.g., cutting, head-banging		

Name: _____ Grade: _____Resident District _____

14. Enuresis or Encopresis (wetting or soiling)		
15. Inability to give or receive appropriate affection to primary caregivers		
16. Inability to accept appropriate limits		
17. Easily angered or excessive anger or other strong emotion.		
18. Frequent, intense, uncontrollable temper tantrums		
19. Verbally threatening		
20. Physically violent		
21. Cruel to animals		
22. Willful destruction of property		
23. Fire setting		
24. Sexually preoccupied or inappropriate sexual activity		
25. Running away		
26. Suspected or confirmed abuse of alcohol or other drugs/substances		
27. Adolescent's pregnancy is/was related to behavioral/emotional difficulties		
28. Parenting (Youth is having trouble parenting his/her child(ren)		
29. Medical condition complicated by emotional disturbance or medical noncompliance		
30. Persistent unrealistic worry over physical health		
31. Problems in school/vocational activity (attendance, behavior, learning, performance)		
32. Suspected or confirmed victim of physical, sexual or emotional abuse		
33. Problems in interpersonal relationships (family and/or authority figures)		
34. Problems in interpersonal relationships (same age peers)		
35. Confirmed or suspected developmental delay		
36. Arrested, detained, or on probation		
37. Homicidal		
38. Gambling		
39. Avoids people, places or things		
40. Always seems jumpy or afraid		
41. Gets upset when remembering bad thing that have happened to him/her.		

MINNEWASKA MENTAL HEALTH SERVICES INTENSIVE OUTPATIENT & DAY TREATMENT REFERRAL

Name: _____ Grade: _____Resident District _____

Provide information about three behaviors or concerns that prompted this referral.
Behavior or concern #1:
Behavior or concern #2:
Behavior or concern #3:

SECTION VI: CHILD/FAMILY SERVICE SUPPORT INFORMATION List services child/family receiving (mental health, probation, child-welfare, other community services

☐ Child Protective Services (CPS) worker _____ Phone # _____

☐ Children's Mental Health worker _____ Phone # _____

☐ Probation Officer _____ Phone # _____

☐ Mental Health Outpatient Clinic agency _____
worker _____ Phone # _____

☐ Other agency _____
worker _____ Phone # _____

☐ Other agency _____
worker _____ Phone # _____

SECTION VII: CURRENT EDUCATION PLACEMENT AND INFORMATION

Regular class in age appropriate grade □ Regular class, retained at grade level ___ □
Special education-in-district program/service □
Day treatment-out-of-district □ Residential program □
Vocational training only □ Not enrolled in school □

MINNEWASKA MENTAL HEALTH SERVICES INTENSIVE OUTPATIENT & DAY TREATMENT REFERRAL

Name: _____ Grade: _____Resident District _____

High school graduate/GED □ Home instruction □
Pre-school □ Other _____
Percent of day in setting III_____or a federal setting V-VIII(Residential, Homebound, Hospital)_____
School District: _____Name of School: _____ Grade: _____
Special Education Case Manager:_____ Phone #/email:_____
District Representative: _____ Phone #/email:_____
Special Education Classification if known:
Emotionally & Behaviorally Disorder □ Learning Disabled □ Hearing Impaired □
Physically Disabled □ Other Health Disability □ Multiple Handicapped □
Pre-School Special Education □ Unknown □
Other school behaviors and concerns:
Truancy/attendance □ Failing grades □ Frequent suspensions □
Poor peer interaction □ Poor teacher interaction □ Physical aggression □
Other (please describe) □ _____
Number of Out of School Suspension_____
Number of In School Suspension_____
Number of restrictive procedures in the current school year_____

Academic Data

Reading	
Estimated Grade Level	
Skill Deficits	
Skill Strengths	
Current MCA Test Results	**Score:_____ ☐ Did Not Meet ☐ Partially Met ☐ Met**
Current Coursework(Curriculum)	

Math	
Estimated Grade Level	
Skill Deficits	
Skill Strengths	
Current MCA Test Results	**Score:_____ ☐ Did Not Meet ☐ Partially Met ☐ Met**
Current Coursework(Curriculum)	

Name: _____ Grade: _____Resident District _____

SECTION VIII: STRENGTHS
Please indicate the family's strengths that may be utilized to assist the child with services:

_____

_____

_____

Please list child's strengths, interests, hobbies, activities:

_____

_____

_____

Thank You!!! Minnewaska Mental Health Services

Please complete and attach the following:

- ❑ Current signed copy of release of information for educational records at residential treatment center/hospital.
- ❑ Current signed copy of release of information between referring district and Minnewaska Area W.I.N. Academy
- ❑ Obtain education records from residential treatment center/hospital.
- ❑ Current signed copy of release of information for diagnostic assessment.
- ❑ Current signed copy of release of information for county worker/social worker.
- ❑ Updated High School Transcript from home district and treatment center/hospital.
- ❑ Immunization Records
- ❑ Current Evaluation Report(not due within the next 6 months)
- ❑ Behavior Intervention Plan
- ❑ Current IEP with any amendments and updated Present Level(s) of Academic Achievement and Functional Performance.
- ❑ Current Prior Written Notice proposing a setting IV placement at Minnewaska Area W.I.N. Academy with mental health services. There needs to be a statement on why W.I.N. Academy is the least restrictive setting and other options considered.
- ❑ Pending acceptance into Minnewaska Area W.I.N. Academy the IEP Service Times need to be reflected prior to starting:

Service	Location	Frequency	Indirect	Direct
Primary Disability	Special Education Classroom	5X week	10	360

MINNEWASKA MENTAL HEALTH SERVICES INTENSIVE OUTPATIENT & DAY TREATMENT REFERRAL

Name: _____ Grade: _____Resident District _____