HEALTHY FAMILIES PROGRAM REFERRAL FORM

Enrollee's Name: ______________________________ DOB: ____________

SSN/Healthy Families Plan Membership #: ____________________ County Identifier #: ____________

Parent/Guardian Name: ______________________________ Phone: ____________

Address: ______________________________ County: ____________

Enrollee's Primary Language: ______________________________

Guardian/Caretaker's Primary Language: ______________________________

Enrollee's Healthy Families Health Plan: ______________________________ Date: ____________

Referring Party: ____________________ Phone: ____________________ FAX: ____________

❒ Designated Health Plan (HP) Representative (e.g., Care Coordinator, Case Manager, etc.)

❒ HP Primary Care Provider ❒ HP Mental Health Provider ❒ HP Alcohol & Other Drug (AOD) Service provider

Address: ______________________________ FAX: ____________

Enrollee's Primary Care Physician (if known): ____________________ Phone: ____________

Address: ______________________________ FAX: ____________

Enrollee's known/suspected Mental Health **Diagnosis** (if any): ______________________________

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Does this Enrollee also have a known/suspected Alcohol & Other Drug Abuse Diagnosis? ❒ Yes ❒ No

If "Yes," list known/suspected AOD Diagnosis: ______________________________

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Enrollee's known/suspected Medical Diagnosis (if any): ______________________________

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Enrollee's current medications (if any): ______________________________

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Date of Enrollee's last WELL CHILD EXAM (if known): ______________________________

Is the Enrollee currently receiving In-patient Psychiatric Services? ❒ Yes ❒ No

Directions for Los Angeles County

The referring health plan or primary care provider (PCP) is to choose from one of the three options provided above and mark the applicable choice. The health plan or the PCP is asked to assist the member in arranging an appointment with a mental health provider, and to then fax this form or send this form with the parents of the member to the mental health provider.

Reason(s) for Referral: Indicate the reason(s) you believe the enrollee MAY be qualified for services for children with Severe Emotional Disturbance (SED)

A. As a result of a mental disorder the enrollee has substantial impairment in the following areas:

- ☐ Self-care
- ☐ School functioning
- ☐ Family relationships
- ☐ Ability to function in the community

B. ☐ The enrollee is at risk for removal from his/her home.
☐ The enrollee has been removed from his/her home.

C. ☐ The mental disorder/impairments have been present for six months, or are likely to continue for more than one year without treatment.

D. ☐ The enrollee displays: psychotic-features, risk of suicide, risk of violence due to mental disorder.

Additional comments regarding behavior, symptoms, medical condition, or other relevant information: ____________

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Signature: ______________________________ Date: ____________________

THE FOLLOWING INFORMATION WILL FACILITATE A THOROUGH MENTAL HEALTH DEPARTMENT EVALUATION. Please check applicable boxes. Following each statement are examples of specific behaviors that may have initiated this referral. Circle any that apply. This list is not meant to be exhaustive. If you have a question about whether or not to check "Yes," please indicate under the COMMENTS section at the end of the form.

Yes
1. This child is or may be a danger to him/herself or to others.

Child may have attempted suicide; made suicidal gestures; expressed suicidal ideation; is assaultive to other children or adults; is reckless and routinely puts self in dangerous situations; attempts to or has sexually assaulted or molested other children; etc.

2. This child has or may have a history of severe physical or sexual abuse or has been exposed to extreme violent behavior.

Child's history involves either being subject or witness to extreme physical abuse, domestic violence or sexual abuse, e.g., severe bruising in unusual areas, being forced to watch torture or sexual assault, witness to murder, etc.

3. This child has or may have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy.

Child may have persistent chaotic, impulsive or disruptive behaviors; may have daily verbal outbursts; refuse to follow basic rules; may constantly challenge authority of adults or attempt to undermine the authority of caregiver with other children; may require constant direction and supervision in all activities, may require total attention of caregiver and be overly jealous of caregiver's other relationships; may be in constant motion which is uncontrolled by medication; may wander the house at night; may be truant from school regularly and not respond to limit-setting or other discipline; etc.

4. The child exhibits bizarre or unusual behaviors.

Child may have a history or pattern of fire-setting; may be cruel to animals; may masturbate excessively, compulsively and/or publicly; may appear to hear voices or respond other internal stimuli (including alcohol- or drug-induced); may have repetitive body motions (e.g., head banging) or vocalizations (e.g., echolalia); may have a pattern or smearing feces; etc.

5. The child has or may have problems with social adjustment.

Child is regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; is regularly truant from school; steals; regularly lies; is mute; is confined due to serious law violations; does not seem to feel guilt after misbehavior, etc.

6. This child has or may have problems making and maintaining healthy relationships.

Child is unable to form positive relationships with peers; may provoke other children to victimize him/her; is involved with gangs or expresses the desire to be; does not form bond with caregiver; etc.

7. This child has or may have problems with personal care.

Child eats or drinks substances that are not food; is regularly enuretic during waking hours (subject to age of child); refuses to tend to personal hygiene to an extreme.

8. This child has or may have significant functional impairment.

There is no known history of developmental disorder and the child's behavior interferes with his/her ability to learn at school; he/she is significantly delayed in language; is "unsocialized" and incapable of managing basic age-appropriate skills; is selectively mute; etc.

9. This child has or may have significant problems managing his/her feelings.

Child has severe temper tantrums; screams uncontrollably; cries inconsolably; has significant and regular nightmares; is withdrawn and uninvolved with others; whines or pouts excessively and regularly; expresses the feeling that others are out to get him/her; worries excessively and is preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; is constantly restless or overactive; etc.

10. This child has or may have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication.

Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.

11. This child is known to use/abuse alcohol and/or other drugs.

Child uses alcohol or other drugs.