Behavior Rehabilitation Services (BRS) Referrals

Date of Referral:

Request Type:  In-Home  Treatment Foster Care (TFC)  Qualified Residential Treatment (QRTP)

Client Name:       Client Preferred Name:

Client Age:       Client DOB:

FamLink PID:       Client Region:

Sex Assigned at Birth: Gender:

LGBTQIA+: Client Pronouns:

Family Location (In-Home Only) City:

Current Placement Setting:

DCYF Case Worker:      Phone Number

Email:

DCYF Supervisor:      Phone Number

Email:

# Youth and Family Strengths and Goals **-** Completed by Assigned DCYF Case Worker

Young Person’s description of hobbies, interests, recreational activities, likes/dislikes, what motivates:

Young Person-identified goals (personal, educational, treatment):

Young Person and Families’ identified culture and cultural needs:

Brief description of family strengths and support needs:

Service Goals (Identified by youth, family, case worker, others):

Brief description of visitation and important relationships and connections for the young person:

# Support Needs and Goals Screening - Completed by Assigned DCYF Case Worker

Mark each applicable behavior(s) exhibited, as current or past (6+ months ago). If the box is checked, provide additional information in the next section. \* Please list all prescribed medications on the medication sheet located on the last page of this referral.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Behavior** | **Current** | **Past** | **Behavior** | **Current** | **Past** |
| Allegation(false) |  |  | Loud vocalizations |  |  |
| Animal Abuse |  |  | Medication Refusal |  |  |
| Biting |  |  | Physical aggression |  |  |
| Bulimia |  |  | PICA |  |  |
| Car Safety |  |  | Property destruction |  |  |
| CSEC |  |  | SAY/RSO |  |  |
| Dietary/Food Sensory |  |  | Sexually inappropriate |  |  |
| Eating Disorder |  |  | Sleep Needs |  |  |
| Elopement |  |  | Substance Use |  |  |
| Encopresis |  |  | Self-injurious |  |  |
| Enuresis |  |  | Sensory |  |  |
| Fire Setting |  |  | Suicidal action(s) |  |  |
| Head banging |  |  | Takes other’s property |  |  |
| Legal (pending, probation, parole, unable to stand trial) |  |  | Verbal aggression |  |  |
| Learning Disability |  |  | Wandering |  |  |

**List current and past treatment services, and current support needs for each domain below.**

Mental Health: Please list all current mental health diagnosis

Behavioral: Please list all current behavior health diagnosis

Physical Health: Please include allergy information. Medication allergies to be listed on Medication Log.

Client Height:       Client Weight:

Education: Please list current school and grade: (  IEP  504)

I/DD: Please list all I/DD diagnosis

Supervision Needs

Substance Use Disorder:

**The list of items below are the supporting documents necessary if they are currently applicable:**

|  |  |  |  |
| --- | --- | --- | --- |
| WISe Screen |  | Current Placement Incident Reports |  |
| Current/Relevant Health Records |  | Picture (if one is available) |  |
| Current/Relevant Mental/Behavioral Records |  | Most Recent Court Report (CFE) |  |
| CHET Screen |  | Visit Plan |  |
| Current/Relevant School Records |  | IDD/DDA Current/Relevant Reports |  |
| Ongoing Mental Health (OMH) Report |  | Child Information Placement Referral (CIPR/15-300) |  |
| Placement History |  |  |  |

# Eligibility Staffing and WISe Screening - Completed by Assigned DCYF Case Worker

Staffing Date Approved for BRS:

WISe Screen Date:       WISe Screen Outcome:  Eligible  Not Eligible

WISe Screen Not Completed

List plan to complete:

# Eligibility and Referral Criteria - Completed by Assigned Intensive Resources Program Consultant

Referred client has behavior and/or mental health support needs that cannot be appropriately managed in a less restrictive setting.  Yes  No

Client experiences severity, intensity, and frequency of behavior that  Yes  No

* Significant impairment of clients functioning and
* Inability to be safely supported in a less restrictive setting
* Assessed to need and likely benefit from specialized treatment due to their complex mental and behavior health needs.

# Approval Signatures

Printed Name:

Case Worker: Date:

Printed Name:

Supervisor: Date:

Printed Name:

Area Administrator: Date:

Printed Name:

IRPC: Date:

# Medication Log and Allergy Information

List ALL Medication Allergies:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Frequency** | **Reason** | **Prescriber** |
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