**CHILDREN’S CLINICAL ON-SITE SERVICES (CCOS)**

**FAX TO 352-357-7723**

### Screening and Referral for Services

Date: \_\_ Referral Source: *Department of Children & Families* Phone #:

Child’s Name: SS# DOB:

Age: Gender: M F School: Mount Dora Middle School ESE? YES NO Grade: 7th

Funding Source:

* Medicaid #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO Name of HMO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Insurance: Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ins. Co. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Self Pay

Parent/Guardian Name: Relationship: \_\_\_\_\_\_ Legal Guardian? YES NO

If guardian is not biological parent, does guardian have court order proving custody of child? YES NO

DCF Worker: Phone:

Parent/Guardian Phone Number(s): [H] [W] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [C]

Home Address: City: Zip Code:

# Presenting Problem/Reason for Referral/Greatest Concern:

LifeStream Client? YES NO

LSBC Program(s)/Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MIS#: \_\_\_\_\_\_\_\_\_\_\_\_\_ LifeStream Staff Referring Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has child received mental health services in the past? YES NO

|  |  |  |
| --- | --- | --- |
| Type of Service: (outpatient, hospitalization, medication clinic) | Provider Name | Dates of Services |
|  |  |  |
|  |  |  |
|  |  |  |

Is the child on any medications? YES NO

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Reason Prescribed | Prescribing Physician | Psychiatrist? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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Screening and Referral for Services

Client:

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Has the child experienced any abuse? YES NO

Indicate type: Emotional: \_\_ Physical: ­\_\_Sexual: \_\_ Neglect: \_\_ Abandonment: \_\_

If yes, did the child receive treatment for abuse? YES NO

When and where treatment was received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever had thoughts or made threats to harm herself/himself? YES NO

Describe:

Date of last thought or statement:

Has the child ever had thoughts or made threats to harm someone else? YES NO

Describe:

Date of last thought or statement:

Has the child been involved with the legal system? YES NO

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DJJ Worker/Probation Officer and Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever used or been suspected of using any drugs or alcohol? YES NO

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance abuse treatment? YES NO

When and where treatment was received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the child involved with any other community agencies? YES NO

|  |  |  |
| --- | --- | --- |
| Agency Name | Worker Name | Phone |
|  |  |  |
|  |  |  |
|  |  |  |

Person Completing Referral: Phone:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRAL FOLLOW UP (to be completed by LifeStream CCOS Staff):

Assigned to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Follow-Up:

# Date Result

\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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