LifeStream BEHAVIORAL CENTER

CASE MANAGEMENT

SCREENING REQUEST

Name: _____ DOB: _____ Sex: ☐Male ☐Female

Race: ☐White ☐Black ☐Multi Racial or Other ☐American Indian or Alaskan ☐Hawaiian or Pacific Islander ☐Asian

Address: _____ MIS #: _____ SS #: _____

City/State/Zip: _____ Telephone: (___) _____

Parent/Guardian: _____ Telephone: (___) _____

School: _____ Grade: _____ ESE? ☐Yes ☐No

Diagnosis: _____

Does this client have Medicaid? ☐ Yes ☐ No If yes, Medicaid #: _____

Presenting Problems: _____

_____

_____

Does this client need multiple community resources? ☐ Yes ☐ No

List Possible Resources: _____

_____

_____

Last Hospitalization (anywhere): _____ Date: _____

Current Medications: (Include dosages and prescribing physician) _____

_____

_____

Is the client amenable to Case Management services? ☐ Yes ☐ No

Comments/Additional Information: _____

_____

_____

Referral Source: _____ Telephone: (___) _____

Date of Referral: _____

FOR CASE MANAGEMENT USE ONLY - DO NOT WRITE BELOW THIS LINE

CASE MANAGEMENT SUPERVISOR'S COMMENTS:

☐ Accepted into Case Management. Assigned to _____ Date _____

☐ Not accepted into Case Management. Comments: _____

_____

☐ Pending/Comments: _____

_____

Assessment Due Date: _____ Service Plan Due Date: _____

YOUTH AND FAMILY RECOVERY (YAFR)

REFERRAL

Date: _____

Youth Name: _____ D.O.B: _____

Caregiver's Name: _____ Relationship to Youth: _____

Caregiver's Phone: _____ Best Time to Contact: _____

1. What is the reason for this referral?

_____

_____

_____

2. Are there any significant issues in the family?

_____

_____

_____

3. Does the caregiver know about this referral? ☐Yes ☐No

4. Are they willing to participate in treatment? ☐Yes ☐No

5. Has a Release to share information been signed? ☐Yes ☐No

Referral Agency: _____ Phone: _____

Contact Person: _____ Cell: _____

Email: _____ Fax: _____

How Did You Find Out About Us? _____

Please Return Forms To:

:

Youth and Family Recovery Program
P. O. Box 491000
Leesburg, FL 34749-1000
Phone: (352) 250-9561

or

Submit by E-Mail to
trand@lsbc.net
(Tracy Rand, lead counselor)

CRII:904:R:2/13

CONFIDENTIAL AND PRIVILEGED
For Professional Use Only

S.U.R.F. Program Referral Form

"Promoting Strong, United, Resilient Families"

Family Information

Child Name _____ DOB _____

Child Name _____ DOB _____

Child Name _____ DOB _____

Caregiver's name_____ Relationship _____

Caregiver's name_____ Relationship_____

Family Phone Number_____ Best Time to Contact _____

Address _____

How could this family benefit from the S.U.R.F. Program?

_____

_____

_____

_____

_____

Referral Information

Date _____Referral Agency _____

Contact Person _____ Title _____

Phone_____ Cell _____ Fax _____

How did you find out about us? _____

Please Return Form To:

Lenore Rosencrans
S.U.R.F. Site Coordinator
(352) 315-7821 (office)
(352) 267-4877 (cell)

Fax: (352) 360-6723
Email: lrosencrans@lsbc.net
Mail: LifeStream Behavioral Center
P.O. Box 491000
Leesburg, FL 34749-1000

Family Intervention Services Referral

REFERRAL SOURCE:_____
Agency Phone Number Date

CLIENT NAME:_____
Last First MI

ADDRESS:_____CITY: _____COUNTY:_____

HOME PHONE: (_____)_____WORK PHONE: (_____)_____CELL PHONE: ( )_____

CHILDREN'S NAMES/AGES:_____, _____, _____

REASON FOR REFERRAL:_____

_____

_____

_____

_____

DCF INVOLVEMENT: ☐**YES** ☐**NO** **If yes, attach intake**

CPI NAME: _____ PHONE: (_____) _____

AND/OR

CHS INVOLVEMENT: ☐**YES** ☐**NO** **If yes, attach case plan**

DCM NAME: _____PHONE: (_____)_____

SUBSTANCE ABUSE? ☐**YES** ☐**NO** CURRENT? ☐**YES** ☐**NO** HISTORICAL? ☐**YES** ☐**NO**

PRIOR TREATMENT? ☐**YES** ☐**NO**

MENTAL HEALTH? ☐**YES** ☐**NO** CURRENT? ☐**YES** ☐**NO** HISTORICAL? ☐**YES** ☐**NO**

PRIOR TREATMENT ☐**YES** ☐**NO**

ABUSE OR TRAUMA? ☐**YES** ☐**NO** CURRENT? ☐**YES** ☐**NO** HISTORICAL? ☐**YES** ☐**NO**

PRIOR TREATMENT? ☐**YES** ☐**NO**

EXPLAIN ANY PRIOR TREATMENT:_____

_____

_____

LifeStream

CHILDREN'S CLINICAL ON-SITE SERVICES (CCOS)

REFERRAL

PRELIMINARY INFORMATION

TO BE COMPLETED BY PARENT/GUARDIAN:

Student's Name: _____

DOB: _____ Social Security #: _____ Age: _____ Gender: _____

Name of Parent(s) or Legal Caretaker: _____

Relationship: _____ Legal Guardian? ☐ Yes ☐ No

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Work Phone Number: _____ Other: _____

Name of Student's School: _____

Payment Source: ☐Medicaid #_____

HMO? ☐Yes ☐No If yes, which: _____

☐Other Insurance: _____ Policy #: _____

Soc. Security # (of insured): _____ Group #: _____

Phone # for Insurance Authorizations: _____

☐Self-Pay

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION (SCHOOL PROGRAM)

I, _____, authorize my child's school, (name of school) _____ to release information about my child, _____, to LifeStream Behavioral Center. I understand that this information is to be used for the purpose of school-based mental health services. I am aware that this release authorizes LifeStream to verify my child's coverage for financial eligibility.

_____ _____

Parent/Guardian Signature Date

TO BE COMPLETED BY REFERRING SCHOOL STAFF MEMBER:

School Status: Mainstream Education ☐

ESE Status: ☐EH ☐SED ☐SLD ☐Other _____

Student's Name: _____ Grade: _____

Reason for Referral: _____

_____

_____

_____

_____

_____

_____

Additional Comments: _____

_____

_____

Referring School: _____ Date: _____

Referring School Staff: _____ Phone: _____

Fax to: **CCOS, (352) 357-7723, ATTN: Dianne Gray Phone #: (352) 357-1550, Ext. 7113**
If you have any questions or wish to confirm the receipt of the referral, you may also follow-up with e-mail to: **Dianne Gray at dgray@lsbc.net.**

TO BE COMPLETED BY CCOS SUPERVISOR OR DESIGNEE:

Assigned To: _____ Date: _____

Clinician Follow-Up:

Date	Result
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Date Opened: _____

CHILDREN'S CLINICAL ON-SITE SERVICES (CCOS)

Screening and Referral for Services

Date:_____ **Referral Source:**_____ **Phone #:**_____

Child's Name:_____ **SS#**_____ **DOB:**_____

Age: _____ **Gender:**_____ **School Attending:**_____ **ESE?** _____ **Grade:** _____

Funding Source:

- ☐ Medicaid #_____ Yes __ No __ If yes, Name of HMO_____
- ☐ Other Insurance: Policy #_____Ins. Co. Name:_____
- ☐ Self Pay

Parent/Guardian Name:_____ Relationship:_____ Legal Guardian? Yes __ No ___
If the guardian is not the child's biological parent, does guardian have legal documents (court order) proving custody of child? Yes ____ No ____

If child is in foster care, who is DCF Worker?_____ Phone #_____

Parent/Guardian Phone Number(s): Home:_____ Work:_____ Cell:_____
Home Address:_____ City _____ Zip Code:_____

Presenting Problem/Reason for Referral (What prompted you to seek help for the child now and what are you must concerned about)?: _____

_____

_____

_____

Is child a current LifeStream Client? If so, list LSBC Program(s) that he/she is currently receiving services:
_____ **MIS#:** _____
LifeStream Staff Referring Child for CCOS Services:

_____

Has the child received mental health services in the past? Yes _____ No _____ If so, please list:

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

Is the child on any medications? Yes ____ No _____ If so, please list:

Name of Medication	Reason Prescribed	Prescribing Physician	Psychiatrist?

Has the child experienced any abuse? Yes __ No ___ If yes, please indicate what type:

Emotional: _____ Physical: _____ Sexual: _____ Neglect/Abandonment: _____

If yes, did the child receive treatment for abuse? Yes ____ No ____ Please list when and where treatment was received:_____

Has the child ever had thoughts or made threats to harm his/her self? Yes ____ No ____
If yes, please describe:_____
Date of last thought or statement:_____

Has the child ever had thoughts or made threats to harm someone else? Yes ____ No ____
If yes, please describe:_____
Date of last thought or statement:_____

Has the child been involved with the legal system?: Yes: ____ No: ____
If so, please describe:_____
_____

Name of DJJ Worker, Probation Worker and Phone Number:_____

Has the child ever used or been suspected of using any drugs or alcohol?: Yes: ____ No: ____
Describe (what substance and when):_____

If so, has the child ever received substance abuse treatment? Yes ____ No ____ Please list when and where treatment was received:_____

Is the child involved with any other community agencies? Yes ____ No ____ If yes, please list (i.e. DCF, JJ, GAL):

Agency Name	Worker Name	Phone Number

Person Completing Referral:_____ Phone/Ext._____

FAX TO: 352.357-7723

To confirm that this referral has been received: 352.357-1550 Ext. 7113 or dgray@lsbc.net

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

Assigned to:_____ Date Assigned:_____

Clinician Follow-Up:

Date	**Result**
_____	_____
_____	_____
_____	_____