**Children’s Crisis Stabilization Services Referral Form**

402 E. University Ave. St. Paul, MN 55130

**Tel: 651-266-7878**

Fax Completed Referral and Assessment Documentation to: **651-266-7874**

A phone call to families for stabilization services will occur the next business day

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| **Referring Agency Information** Date of Referral: Number of Faxed Pages: | | | |
| Agency: | Unit: | Phone: | Fax: |
| Contact Person: | Phone: | Fax: | Pager: |

**Client Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| First Name: | | | Last Name: | | | DOB: | Age: |
| Gender: | Race: | School (if known): | | | Who else lives with this person? | | |
| Parent #1/Guardian Name & Phone: | | | | Parent #2/Guardian Name & Phone: | | | |
| Address: | | | | | | | |
| Insurance: | | | ID: | | | Group: | |
| **Current Services/Providers: Please list provider name/number if known** | | | | | | | |
| **🞏**  **Case Management:** | | | **🞏 Psychiatry:** | | | **🞏**  **School Services:** | |
| **🞏**  **Family Services:** | | | **🞏**   **Therapy:** | | | **🞏 Other:** | |

**Diagnostic Information (Please attach current information on: hospitalizations, treatment recommendations, follow up appointment and meds)**

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| --- | --- | --- | --- |
| Current Diagnosis: | | Trauma History: | |
| Current or Recent Chemical Use: 🞏 Yes 🞏 No Is there a history of Chemical Abuse/Dependence: 🞏 Yes 🞏 No Date of Last Use: \_\_\_\_\_\_\_\_\_\_\_\_\_  Drug (s) of Choice: | | | |
| Is this individual dangerous to self or others (currently or by history)? 🞏 Yes **🞏**  No Describe: | | | |
| **Current Mental Health Symptoms** | | | |
| 🞏 Suicidal (ideation or attempt) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **🞏**  Anxiety/Panic | 🞏 Self Injurious Behavior (non suicidal)  🞏 Threatening to Others  🞏 Psychotic or Delusional | | 🞏 Aggression/property destruction  🞏 Trauma/PTSD/RAD  🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Briefly Describe Current Mental Health Crisis and Service Need:** Victoria Jefferson called 911 in fear due to parents fighting with dad hitting himself and accusing mom of having an affair. Mom appeared stressed stating that she is the full time caregiver for both her children who have Autistic, and father is not supportive in additional services to help with the children. Parents have guardianship over the children, both parent’s agreed the family could benefit from resources.  Safety concerns in the home? 🞏 Yes **🞏**  No Describe: Daughter called stating she feared dad had a gun, dad states all guns are locked away in safe spot. | | | |

**Stabilization Services Requested**

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| --- | --- | --- |
| **🞏**  Crisis/Safety Planning | **🞏**  Crisis Counseling/Coping Skills Development | 🞏 Connection to Mental Health Resources |
| **🞏**  School support/reintegration | **🞏**  Family Support/Coping | 🞏 Diagnostic Assessment |

**AUTHORIZATION FOR THE RELEASE OF PERSONAL INFORMATION**

|  |
| --- |
| I have informed my client’s parent of this referral: **🞏**  Yes 🞏 No Parent/child is interested in services as above: **🞏**  Yes 🞏 No  I understand that the above information as well as any health information about me is protected under state and/or federal privacy laws and cannot be disclosed without my written authorization unless otherwise provided for by state and federal law. I understand that records from my visit are being released to Urgent Care for Adult Mental Health. I have been told why I am being asked to consent to the release of this information. I voluntarily and knowingly waive those protections of this information and consent to its release to Urgent Care Adult Mental Health for the purpose of referral for services. I understand that I may revoke this consent upon written notice. My consent will automatically expire one year from the date of my signature below.  Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date |