Dear Stakeholder,

In order for Whitaker PRTF to consider a referral, screening and prioritization of the applicant must take place at the LME level. The Secure Residential Packet attached to this letter must be completed and submitted to the local Community Collaborative for review.

Referral packets should be completed by the Community Support Provider, along with the Child and Family Teams, and reviewed by the Community Collaborative. A decision should be made with regards to the appropriateness of the referral. The child should be prioritized within the context of other referrals from the LME. The Chairperson of the Collaborative and the LME Director (or the Director’s designee) must sign in the appropriate space at the bottom of the page for the referral to be considered. The completed referral packet should then be sent directly to Whitaker PRTF.

The referral authorization below must be completed and mandatory information provided for an application to be processed. In order for a child to remain prioritized on the list, bi-monthly updates from the LME must be sent to Whitaker PRTF. The form for this update is located on the last page of this packet. Updates should be faxed to 919-575-7489.

If you have questions, please contact Whitaker PRTF at 919-575-7927 (dial 0 for the operator) with any questions. You will be connected with someone who can help.

Thank you,
Ray Newnam, Ph.D.
Senior Psychologist, Whitaker PRTF
Ray.Newnam@dhhs.nc.gov
(919) 575-7105

Authorization of Referral
Name of LME: ______________________________________ ________________________________

Approved by Director or Designee: ______________________________________________________ DATE

This referral has been reviewed and approved by:

Community Collaborative Chairperson/Child and Family Coordinator/LME Director Date

Our Program has _____ number of children referred. This child is prioritized at number ____ on the list (#1=top priority).
IDENTIFYING INFORMATION

Name: ___________________________________________ Date of Birth: _____ / _____ / ______
Sex: □ Male □ Female  Height: _____  Weight: _____  County of Residence: _________________
Referring LME: ______________________________________
Referring Case Support Provider: ________________________________________________________
Phone/Fax: ______________________________________
Funding Source(s): □ Medicaid  □ Private Insurance ______________________________________
Name and ID # of Private Insurance ______________________________________________________

CURRENT STATUS

Custody: □ DSS □ Parent(s) □ Other Family Member(s). Is the resident adopted? □ Yes □ No
Legal Guardian(s): __________________________________________
Address: ______________________________________________________
Phone: _______________________________________________________
Applicant’s Current Placement: ______________________________________
Address: ______________________________________________________
Phone: _______________________________________________________

DEMOGRAPHIC INFORMATION AND PERSONAL HISTORY

Does this child have a family permanently committed to him/her?  Yes □ No □
If “yes”, how will this child’s family be involved in treatment during placement? If “no”, who will represent this child in the role of surrogate parent? ____________________________________________

Family: (age, occupation, health, education, location, status of relations with child)
□ biological □ adoptive
Mother: __________________________________________________________________________
________________________________________________________________________________
Father: __________________________________________________________________________
________________________________________________________________________________
Siblings: __________________________________________________________________________
________________________________________________________________________________
Involved Extended Family / Step-parents / Grandparents / Foster Parents: ______________________
________________________________________________________________________________
**Significant Developmental History:**
- None Known  
- Yes, explain: 

**History of Loss / Trauma, Abuse &/or Neglect:**
- No  
- Yes, explain below
- Physical
- Sexual

**Family History of Mental Illness / Substance Abuse:**
- No  
- Yes, describe:

---

**DIAGNOSTIC INFORMATION**

**Most Recent DSM-IV Diagnoses/Date of Diagnosis**

| I. | | |
| II. | | |
| III. | | |
| IV | | |
| V (GAF) | | |

**Previous Diagnoses:** (check all that apply):
- Anxiety
- Reactive Attachment Disorder
- PTSD
- Conduct Disorder
- Personality Disorder
- Depressive Disorder
- ADHD/ADD
- ODD
- Bipolar Disorder
- Pervasive Developmental Disorder
- Autism Disorder
- Asperger Syndrome
- Mental Retardation
- Schizoaffective Disorder
- Other(s):

**Medical Problems:**

**Current Medications (Dosages):**
Social Supports: □ Family  □ School  □ Friends □ Local Mental Health Staff □ Guardian/DSS  □ Spiritual □ Other: ____________________________________________ □ None  
Cultural, Spiritual, Religious Orientation / Information: ____________________________________________ □ None

Most Recent IQ (FSIQ, Verbal Comprehension Index, Processing Speed, Working Memory, and Perceptual Reasoning Index)/Level of Functioning Assessments/Dates of Testing:

Note: *** If Verbal Comprehension Index is below 75 or Full Scale is below 70, it would be unlikely the applicant would benefit from the program. A referral to the STARS program at Murdoch is recommended.***

WISC-IV Date_____________ Considered Valid? □ Yes □ No  
Verbal: ____   Perceptual ________ Memory_________ Processing Speed _______ Full Scale IQ_____

Educational History:  Last School Attended: ____________________________  
Last Grade Completed: 6, 7, 8, 9, 10, 11, 12, GED □ Repeated Grades, explain: ____________________________

Exceptional Resident Status: □ None □ SED □ Other Health Impaired □ Learning/Language Disabled  
Attendance: □ Good □ Poor □ None, Explain: ____________________________  
□ Suspensions: ____________________________________________________  
□ Expulsions: ____________________________________________________  
□ Homebound / In-Home Teaching: ______________________________________

Additional Pertinent Educational Information: ____________________________

Current and Previous Legal Status: □ N/A □ Current or Pending Legal Charges □ Past Charges  
□ Current Probation _______to_________   □ Juvenile □ Adult   
Court Counselor: ____________________________________________________  
Phone/FAX #’s: __________________________________________ County: ____________________________  
Detention □ No □ Yes Dates: __________________________________________  
Youth Academy □ No □ Yes Dates: ________________________________  
Adult Jail □ No □ Yes Dates: __________________________________________

Strengths  □ Has residence to return to upon discharge  □ Supportive family / friends  □ History of cooperation with outpatient treatment  □ History of successful employment  □ Financial Resources  □ Expresses need for help  □ Other: ____________________________

Deficits □ Possibly / cannot return to prior residence  □ No or limited supportive family / friends  □ History of treatment non-compliance  □ Poor or no employment History  □ Poor or no financial resources  □ Limited or no financial resources  □ Other: ____________________________
### Symptoms / Behavior Changes:

<table>
<thead>
<tr>
<th>Suicidal</th>
<th>Overdose</th>
<th>Self-injurious behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicidal</td>
<td>Physical aggression</td>
<td>Temper tantrums</td>
</tr>
<tr>
<td>Conflict with family</td>
<td>Physical threatening</td>
<td>Verbal threatening</td>
</tr>
<tr>
<td>Mood swings</td>
<td>Property destruction</td>
<td>Running away</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Agitation</td>
<td>Irritability / Anger</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>Sleep disturbance</td>
<td>Decreased energy</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Paranoia</td>
<td>Poor judgment</td>
</tr>
<tr>
<td>Decline in Self-care</td>
<td>Delusions</td>
<td>Disorganized thinking</td>
</tr>
<tr>
<td>Anhedonia</td>
<td>Concentration problems</td>
<td>Pressured speech</td>
</tr>
<tr>
<td>Weight change</td>
<td>Appetite Change</td>
<td>Memory impairment</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Gang Involvement</td>
<td>Hopelessness / Guilt</td>
</tr>
<tr>
<td>Sexual acting out:</td>
<td>Promiscuity</td>
<td>Offending: Victims</td>
</tr>
</tbody>
</table>

### Primary Symptoms/Behaviors (check all that apply)

<table>
<thead>
<tr>
<th>Primary Symptoms/Behaviors (check all that apply)</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>If yes, describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotic</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Assaultive</td>
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<tr>
<td>Destructive</td>
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<tr>
<td>Suicidal or Self-Destructive</td>
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<tr>
<td>Runaway Tendencies</td>
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<tr>
<td>Sexual Acting Out</td>
<td></td>
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<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>
Additional Information: ________________________________________________________________

Substance Abuse History: □ Patient Denies  □ None Known  □ Not Applicable  □ Yes
□ Alcohol
Stimulants: □ Dexadrine  □ Ritalin  □ Methamphetamines  □ Cocaine  □ Powder  □ Crack  □ Cannabis
Designer Drugs: □ Ketamine  □ Ecstacy  □ GHB  □ Rohypnol
Opioids: □ Heroin  □ Morphine  □ Oxycodone  □ Methadone  □ Darvocet  □ Opium  □ Codeine
□ Other
Hallucinogens: □ LSD  □ Mescaline  □ PCP/Angel Dust  □ Psilocybin Mushrooms  □ Other:
Inhalants: □ Gasoline  □ Amyl Nitrates  □ Paint  □ Other

Concerns in Home and Community: (indicate area(s) of needs, problems, or barriers)
□ Primary Support System  □ Economic  □ Educational  □ Occupational  □ Legal  □ Health Care
Explain: ________________________________________________________________

Behaviors or conditions that make continued placement in the home community difficult.
________________________________________________________________________

List and describe interventions/placements previously tried and which aspects were successful/unsuccessful (include out-patient treatment, residential, hospitalization, etc.)

If there are additional placements, please attach.

<table>
<thead>
<tr>
<th>Treatment Intervention/Placement</th>
<th>Dates</th>
<th>Applicant Response</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
ECOLOGICAL INFORMATION

***NOTE: EACH RESIDENT MUST HAVE A VISITING RESOURCE FOR MANDATORY, TWICE-MONTHLY VISITS IN THE COMMUNITY IN A SAFE AND SUPERVISED ENVIRONMENT FOR SUCCESSFUL REINTEGRATION INTO THE COMMUNITY. STEP DOWN PLACEMENTS MUST BE INDICATED AND APPROPRIATE.***

Identification/Description of Visiting Resource: __________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Plans for transportation to and from Visiting Resource: _________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Discharge Plan - Whitaker PRTF prepares residents to live in less restrictive environments on discharge. However, the problems of our residents are more severe than most. They continue to need intense services (though not in a locked facility) after they leave Whitaker.

Anticipated Needs Upon Discharge: Can resident return to prior living arrangement?: [ ] Yes [ ] No

Refer to local Mental Health / Developmental Disability / Substance Abuse Services with following recommendations:

<table>
<thead>
<tr>
<th>Individual Therapy</th>
<th>Community Support Services</th>
<th>Developmental Disability Services</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Therapy</td>
<td>Group Home Placement</td>
<td>Multi-systemic Therapy (MST)</td>
<td>Social Security / SSI</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>Legal Services</td>
<td>Psychiatric Residential Treatment Facility</td>
<td>Medication Financial Assistance</td>
</tr>
<tr>
<td>Case Management</td>
<td>Supportive Employment</td>
<td>Diagnostic Assessment</td>
<td>Day Treatment</td>
</tr>
<tr>
<td>Intensive In-Home Psychiatric Services</td>
<td>Partial Hospitalization</td>
<td>Child &amp; Adolescent Day Treatment</td>
<td>Need Guardian</td>
</tr>
<tr>
<td>Assertive Community Treatment Team (ACTT)</td>
<td>Medication/Symptom Management</td>
<td>Public School Education / Evaluation</td>
<td>Self-Help Group / AA, etc.</td>
</tr>
<tr>
<td>Mobile Crisis Management</td>
<td>Outpatient Commitment</td>
<td>Public Health/Home Health</td>
<td>Speech, PT, OT Services</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>Leisure Activity</td>
<td>1:1 Mentor</td>
<td>Weekly 1:1 Time with Parent / Guardian</td>
</tr>
</tbody>
</table>

Other Recommendations:

TREATMENT ISSUES

Why are you referring? ____________________________________________________________

List questions that need to be answered for the child to be successfully maintained in the community? ____________________________________________________________

What services will the LME provide while the applicant is in Placement? ________________

_________________________________________  ________________________________
Signature:  Date:  
Person Making Referral

_________________________________________  ________________________________
Signature:  Date:  

For the referral packet to be placed on the waiting list, all starred items must be provided in the packet. The packet will remain on a prospective list until this information is provided. **NOTE:** Developmentally disabled and/or mentally retarded residents should be referred to the STARS Program at Murdoch Center. (Phone Number: 919-575-1070)

*Psycho-educational Testing:* (NOTE: To be considered, a psychological with IQ scores that are within 24 months of the referral is mandatory. The entire report must be sent, not just the scores)

*________ Psychosocial Assessments

*________ Psychological Testing Including IQ Testing (within the last 2 years)

*________ Admissions Assessment Psychiatric Hospitals or Mental Health Centers

*________ A detailed Life Chart or a thorough Developmental/Social History

*________ Discharge Summaries from Prior Treatment Facilities (if applicable)

*________ Achievement testing (most recent but within the last 3 years)

*________ School Transcripts (most recent)

*________ Report cards (most recent and previous report cards for the entire current school year)

*________ Standardized testing (End of Grade [EOG 5-8] and End of Course [EOC 9-12] tests, Computer skills, Reading/Math competencies)

*________ Exceptional Children’s Forms to include **all DEC forms** (DEC 1-7 and a current IEP (DEC 4) that indicates SED, LD, OHI, other)** Please note that if a child has been identified as an Exceptional Child (EC), legally s/he should have a current IEP.**

*________ Vision and Hearing Screenings (Recent)

*________ Current Physical and Immunization Records

*________ Referral packet information sheets.

*________ Copy of social security card

*________ Copy of birth certificate. (if available)

*________ Consent to Exchange Information Form

________ Older report cards from previous school years.

________ Older psychological testing.
________ Psychiatric Assessment (mandatory if available)

________ Personality Assessments (if available)

________ Discharge Summaries from Psychiatric Hospitalizations (if applicable)

________ Neurological Testing (if applicable)

________ Speech/Language Evaluation (if applicable is mandatory)

________ Most Recent LME Service Plan which includes: Goals, Strengths, and Weaknesses.

________ DSS Reports (if applicable)

________ Juvenile Court Reports (if applicable)

________ Staffing Notes from the Collaborative Meeting

________ Other_____________________________________

________ Other_____________________________________

10
North Carolina Department of Health and Human Services
Division of MH/DD/SAS
Child and Family Services Section
SECURE CARE REFERRAL UPDATE SHEET

*** (THIS SHEET IS NOT PART OF THE ADMISSIONS PACKET. IF THE CHILD HAS TO WAIT FOR A BED, IT SHOULD BE FILLED OUT AT LEAST BI-MONTHLY AND FAXED TO 919-575-7489 IN ORDER FOR THE CHILD TO REMAIN IN CONSIDERATION FOR ADMISSION)***

Client’s Name: _____________________________ Date of Approval: ___________________

LME: ____________________________________ Date: __________________________

Check appropriate box for any new or additional information completed since the last update.

☐ IEP ☐ Psychological Evaluation
☐ DEC Forms ☐ Medicaid
☐ Treatment Plan ☐ Hospitalization
☐ Therapy ☐ Visiting Resource/Step Down
☐ Medication ☐ Other

Please attach a copy of all new or additional information.

Describe any significant life events and/or changes to his/her living situation since the last update.

________________________________________________________________________
________________________________________________________________________

Describe any contact with the legal system; courts; and/or police since the last update?

________________________________________________________________________
________________________________________________________________________

Describe any aggression, physical violence towards others, and/or self-injurious behavior since the last update.

________________________________________________________________________
________________________________________________________________________

Outline changes in services received since last update.

________________________________________________________________________
________________________________________________________________________
Priority ________________

____________________________________

Case Manager Signature           Date