**DHHS Children’s Assessment Clinic Referral Form**

**Please check location:** [ ]  **Murdoch** [ ]  **Riddle**

|  |
| --- |
| **Date of Referral:**  Click here to enter a date.**Child’s Name** (First, Middle, Last): Click here to enter text.Gender: [ ]  Male [ ]  Female Medicaid ID #: Click here to enter text.Date of Birth: Click here to enter text. Age: Click here to enter text. SIS score: Click here to enter text.County of Residence: Click here to enter text. DD-SNAP Score: Click here to enter text. |
|  |
| **Reason for Referral:**  |
|  |
| **Legal Guardian(s)** *(Please list ALL persons having LEGAL guardianship REGARDLESS of location or degree of involvement)*: Guardian Name: Click here to enter text. Relationship: Click here to enter text.Home/Mobile Phone: Click here to enter text. Work Phone: Click here to enter text.Address (Street, City, State, Zip): Click here to enter text.County: Click here to enter text. E-mail: Click here to enter text.Guardian Name: Click here to enter text. Relationship: Click here to enter text.Home/Mobile Phone: Click here to enter text. Work Phone: Click here to enter text.Address (Street, City, State, Zip): Click here to enter text.County: Click here to enter text. E-mail: Click here to enter text. |
|  |
| **Responsible LME/MCO:** Click here to enter text. Care Coordinator: Click here to enter text.LME/MCO E-mail: Click here to enter text. Office Phone: Click here to enter text.Mobile: Click here to enter text. Fax: Click here to enter text. |
|  |
| **Most current Psychological Testing**Adaptive Assessment: Click here to enter text. Results: Click here to enter text. Year: Click here to enter text.Cognitive Assessment: Click here to enter text. IQ: Click here to enter text. Year: Click here to enter text. |
|  |
| **Qualifying Diagnoses *(and dates acquired)*** |
| Intellectual/Developmental:       |
| Mental Health:       |

|  |
| --- |
| **Other Known Medical Issues or Diagnoses:** |
| [ ]  Allergies to Medications:  Click here to enter text.[ ]  Allergies to Foods: Click here to enter text. Click here to enter text.[ ]  Asthma[ ]  Constipation | [ ]  Dental problems[ ]  Diabetes[ ]  Enuresis/Encopresis[ ]  Ear Infections[ ]  Feeding/Eating Difficulties  Click here to enter text.[ ]  GERD/Reflux | [ ]  Seasonal Allergies[ ]  Seizure Disorder Type: Click here to enter text. Frequency per week: Click here to enter text. [ ]  Other: Click here to enter text.[ ] Other: Click here to enter text.[ ] None |
| Alcohol use? [ ]  No [ ]  Yes (if yes, describe: Click here to enter text.) |
| Drug use? [ ]  No [ ]  Yes (if yes, describe: Click here to enter text.) |
| In a recovery progam? [ ] No [ ]  Yes (if yes, describe: Click here to enter text.) |
| Weight: Click here to enter text. Height: Click here to enter text. |
| Average hours of sleep per night: Click here to enter text. |
| Recent changes or concerns about… |
| - sleep pattern? [ ] No [ ]  Yes (if yes, explain: Click here to enter text.) |
| - appetite? [ ] No [ ]  Yes (if yes, explain: Click here to enter text.) |
|  - energy level? [ ] No [ ]  Yes (if yes, explain: Click here to enter text.) |
| - bowel or bladder habits? [ ]  No [ ]  Yes (if yes, explain: Click here to enter text.) |
| - fine or gross motor skills? [ ] No [ ]  Yes (if yes, explain: Click here to enter text.) |
| Ambulation issues? [ ] No [ ]  Yes (if yes, explain: Click here to enter text.) |
| Hearing problems? [ ]  No [ ]  Undetermined [ ]  Yes (if yes, explain: Click here to enter text.) |
| Vision problems? [ ] No [ ]  Undetermined [ ]  Yes (if yes, explain: Click here to enter text.) |
| Sensory issues? [ ] No [ ]  Yes (if yes, explain: Click here to enter text.) |
| Adaptive equipment? [ ]  No [ ]  Yes (if yes, describe item(s) & reason(s):      ) |
| Assistive devices? [ ] No [ ]  Yes (if yes, describe item(s) & reason(s):      ) |
| Protective equipment? [ ] No [ ] Yes (if yes, describe item(s) & reason(s):      ) |
| Currently sexually active? [ ] No [ ]  Unknown [ ]  Yes (if yes, explain:     ) |
|  |

|  |
| --- |
| **Communication** |
| Primary language of child/in child’s home: Click here to enter text.  |
| Communication deficits? [ ] No [ ]  Yes (if yes, explain: Click here to enter text.) |
| Primary Mode of Expressive Communication: |
| [ ]  Verbal (if yes, please indicate below)[ ]  Single words[ ]  Phrases[ ]  Sentences[ ]  Nonverbal | [ ]  Sign language[ ]  Pictures/photos[ ]  Device (Click here to enter text.)[ ]  Other (Click here to enter text.) |
| How does the child indicate they are experiencing pain/discomfort?       |
| Receptive Communication: |
| Does the child attend to… [ ]  verbal language [ ]  gestures and/ auditory cues [ ]  visual cues?Does the child understand… [ ]  1-step directions [ ]  2-step directions [ ]  3-step directions?Can the child answer… [ ]  “yes-no” questions [ ]  “what” questions [ ]  “where” questions  [ ]  “how” questions [ ]  “why” questions? |
|  |
| **Socialization** |
| [ ]  Initiates interaction | [ ]  Responds to interaction |
| [ ]  Avoids interaction | [ ]  No response to interaction |
| [ ]  Prefers interaction with males | [ ]  Prefers interaction with females |
|  |
| **History of Hospitalizations, Developmental Center Admissions, & Out-of-Home Placements (group home, AFL, respite, etc.)** |
| Facility Name & Location | Dates | Primary Reason for Admission |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  |

|  |
| --- |
| **Historical Medications used for Behavior Management** (such as Prozac, Lexapro, Zoloft, Ritalin, Concerta, Adderall, Vyvanse, Clonidine, Tenex/Intuniv, Lamictal, Lithium, Depakote, Tegretol, Risperdal, Abilify, Zyprexa, Seroquel, Latuda, N-Acetyl-Cysteine, Ativan, Klonopin) |
| Name | Dose | How long taken? | Affects | Reason for D/C |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  |
| **Medical & Dental Information** |
| Name | Phone Number | Date last seen | Reason |
| Primary Care Provider:Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| Dentist:Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| Psychiatrist:Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| Neurologist:Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| Other: Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| Other: Click here to enter text. | Click here to enter text. | Click here to enter a date. | Click here to enter text. |
| How does the child normally respond to medical appointments/examinations? Is sedation or immobilization typically required?       |
| Have there been any recent suspicions of pain or physical distress?  *(If so, please describe.)*       |
|  |

|  |
| --- |
| **Current Medications & Supplements** |
| Name of Medication | Dose | Purpose | How long taking? |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  |
| **General/Miscellaneous Information** |
| What funding does the child currently receive?*(Check all that apply)* |
| [ ]  Innovations Waiver[ ]  Medicaid B3 Waiver[ ]  Medicaid[ ]  MFP (Money Follows Person) | [ ]  EPSDT[ ]  IPRS (State Funded Services)[ ]  None[ ]  Other |
| Where does the child currently live? |
| [ ]  At home with family/guardian[ ]  ICF-IID Group Home[ ]  Supervised Living Group Home (5600 B)[ ]  Supervised Living AFL | [ ]  Therapeutic Foster Care[ ]  MH Group Home–Level Click here to enter text.[ ]  PRTF[ ]  Other: Click here to enter text. |

|  |
| --- |
| **General/Miscellaneous Information *- Continued*** |
| What services has the child been approved for? *Check all services approved for.* Of the approved services, what services is the child actually receiving? *Circle or highlight/bold all services being received.* |
| [ ]  ABA Therapy[ ]  Care Coordinator [ ]  Case Management[ ]  Community Living and Supports [ ]  Community Navigator[ ]  Counseling/General Therapy[ ]  Day Supports[ ]  In-Home Skill Building[ ]  Intensive In-home[ ]  Occupational Therapy | [ ]  Personal Assistance[ ]  Personal Care Services[ ]  Physical Therapy[ ]  Multi-Systemic Therapy[ ]  Residential Supports[ ]  Respite[ ]  Specialized Consultative Services [ ]  Speech Therapy[ ]  Other: Click here to enter text.[ ]  Other: Click here to enter text.[ ]  None |
| How many hours of support does the child receive each week? Click here to enter text. |
| Has the child been referred to NC-START? [ ]  No [ ]  Yes (if yes, give date: Click here to enter a date.)Is NC-START actively involved at this time? [ ]  No [ ]  Yes (if yes, coordinator name/contact  information: Click here to enter text.) |
| What makes the child happy? What do they enjoy doing? What are their favorite items/activities?       |
| What makes them unhappy? What do they dislike doing? What are their least favorite activities/tasks?      |

|  |
| --- |
| Self Help Skills: Please rate the child’s ability in completing the following self-help skills using the listed codes: I = Independent V = Verbal Prompt P = Physical Assistance T = Total Dependence[ ]  Eating/drinking [ ]  Tooth brushing[ ]  Meal Preparation [ ]  Toileting[ ]  Dressing/Undressing, including closures [ ]  Bathing/Showering |
| Identify and then describe everything you can about the person(s) who are the most successful working with the child? *(Are they soft spoken/loud, male/female, flexible/stern, easy going/rigid, unintimidated/afraid, etc.)*       |
| Identify and then describe everything you can about the person(s) who are the least successful working with the child?       |
| Does the child have a history of exposure to mistreatment or potentially traumatic events? If so, please describe.       |
| Does the child have a Behavior Support Plan at home? [ ]  No [ ]  YesDoes the child have a Behavior Support Plan at school? [ ]  No [ ]  YesIf yes, name & contact information for responsible psychologist: Click here to enter text. |
|  |

|  |
| --- |
| **Behavioral Profile:** What problematic behaviors does the child exhibit? |
| **Behavior** | **Behavioral Description** (explain what the behavior typically looks like; mark N/A if the behavior is not an area of concern for the child) | **Frequency**(daily, weekly, monthly) | **Intensity**(1 = Low intensity; 5 = High intensity) | **Location(s) where behavior occurs**(home, school, community) |
| Physical Aggression | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| PropertyDestruction | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Self-InjuriousBehavior | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| InappropriateVerbal Behaviors | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Elopement/Darting | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Non-compliance/Refusal Behaviors | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Deviant Sexual Behaviors | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Suicidal Attempts, Gestures, or Threats | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Disruptive Behaviors | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Unsanitary Beh. (e.g., feces smearing, spitting) | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Stealing | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Stripping | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Self-Stimulatory Behaviors | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Toileting Accidents/Incident | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Pica/ingestion of inedible items | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Hallucinations (visual or auditory) | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Animal Cruelty | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Fire Setting | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Other | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Other | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| How long have these behavioral issues been going on?       |
| What injuries, damage, or legal issues have occurred because of behaviors?       |
| What issues/circumstances/things seem to provoke or increase the likelihood that problem behaviors occur (i.e., triggers)?       |
| Can you tell when the child is going to have a problem (i.e., precursors, early warning signs)?      |
| Are there circumstances in which problematic behaviors are less likely to occur?       |
| What strategies have been successful in preventing behaviors from occurring?      |
| What interventions have been successful in stopping the behavioral episode and restoring calm?       |
| What does the child find reinforcing or rewarding?       |
|  |

|  |
| --- |
| **Educational Information** |
| Current grade level: Click here to enter text. Date of Last IEP meeting: Click here to enter a date. Date of Last Functional Behavioral Assessment: Click here to enter a date. |
| Where does the child attend school? |
| [ ]  Public school Name: Click here to enter text. County: Click here to enter text. Area of Eligibility: Click here to enter text. Classroom ratio: Click here to enter text. | [ ]  Non-Public school Name: Click here to enter text. County: Click here to enter text. Area of Eligibility: Click here to enter text. Classroom ratio: Click here to enter text. |
| [ ]  Home schooled[ ]  Does not attend school[ ]  Other: Click here to enter text. |
| How many hours does the child attend school each day? Click here to enter text. |
| What additional education supports does the child receive? |
| [ ]  1:1[ ]  2:1[ ]  Private tutor | [ ]  Assigned mentor[ ]  Other: Click here to enter text.[ ]  None |
| How many suspensions/expulsions from schools has the child experienced?  |
| How many of these occurred within the past 2 years? Click here to enter text. |

Along with the referral, please include any available documents listed below:

* Latest Psychological evaluation
* Latest Psychiatric evaluation
* Recent hospital discharge summaries
* Other relevant evaluations (e.g., Comprehensive Clinical Assessment, PT/OT, SLP, Audiology, Neurology)
* Current IEP (including FBA)
* Current ISP
* Copy of most recent annual physical
* Latest lab results
* Current Behavior Support Plan/Behavior Guidelines

Name(s) of LME/MCO/CC making referral:

Click here to enter text.

Click here to enter text.

Click here to enter text.

*Please e-mail the completed referral to Murdoch at* *MDCAssessment.Clinic@dhhs.nc.gov* *or to Riddle at* *JIRAssessment. Clinic@dhhs.nc.gov**.*