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

**Please check location:  Murdoch  Riddle**

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| **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. |
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| **Reason for Referral:** |
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| **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. |
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| **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. |
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| **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. |
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| **Qualifying Diagnoses *(and dates acquired)*** |
| Intellectual/Developmental: |
| Mental Health: |

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| **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:     ) | | |
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| **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? | | | |
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| **Socialization** | | | |
| Initiates interaction | | Responds to interaction | |
| Avoids interaction | | No response to interaction | |
| Prefers interaction with males | | Prefers interaction with females | |
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| **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. |
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| **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. | |
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| **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.)* | | | | | | | | |
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| **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. |
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| **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. | | | |

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| **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? | |

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| 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  Yes  Does the child have a Behavior Support Plan at school?  No  Yes  If yes, name & contact information for responsible psychologist:  Click here to enter text. |
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| **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. | |
| Property  Destruction | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | |
| Self-Injurious  Behavior | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | |
| Inappropriate  Verbal 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? | | | | |
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| **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*](mailto:MDCAssessment.Clinic@dhhs.nc.gov) *or to Riddle at* [*JIRAssessment. Clinic@dhhs.nc.gov*](mailto:JIRAssessment.Clinic@dhhs.nc.gov)*.*