Dear Stakeholder,

Referral packets should be completed by the referring Provider/Consumer along with the Child and Family Team. If the placement is to be funded by Medicaid, the case should be reviewed by the local Care Review Committee, through the local Center of Care (COC)/MCO. A decision should be made with regards to the appropriateness of the referral and the child should be prioritized in the context of other referrals from the COC. A representative of the COC 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. If the applicant does not have Medicaid, the completed referral packet may be sent directly to Whitaker.

The referral authorization below must be completed and mandatory information provided, for an application to be processed. If the applicant is determined to be appropriate, a Social Worker from Whitaker will contact the referring party to make arrangements for admissions.

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

Thank you,
Jenn Cook, M. Ed.
Social Worker III, Whitaker PRTF
jenn.cook@dhhs.nc.gov

Authorization of Referral

Name of COC/MCO: ____________________________________________________________

Approved by COC/MCO Representative: __________________________________________ DATE
1. IDENTIFYING INFORMATION

Name: ________________________________
Date of Birth: __/__/____    Sex: □ Male □ Female   Height ____ Weight________
County of Residence: __________________________________________________________
Referring Mental Health Area Program: ___________________________________________
Referring Case Support Provider: _________________________________________________
Address: _________________________________________________________________
Phone: ________________________________
D.S.S. Worker: ________________________________
Address: _________________________________________________________________
Phone/Fax: ________________________________
D.J.J. Worker: ________________________________
Address: _________________________________________________________________
Phone/Fax: ________________________________
Funding Source(s): Insurance/Medicaid #’s for Treatment Expenses:__________________
________________________________________
Allowance/Personal Effects Provider: ________________________________
________________________________________

1. CURRENT STATUS

Legal Guardian: ________________________________
Address: __________________________________________
________________________________________
Phone: ________________________________
Applicant’s Current Placement: ________________________________
Address: __________________________________________
________________________________________
Legal Status /Juvenile Court Involvement:____________________________________
Current Educational Placement/Exceptionality/Grade Level:____________________

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>
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http://www.ncdhhs.gov/dsohf/services/whitaker.htm
Telephone: 919-575-7927 General Fax: 919-575-7895 Confidential Fax: 919-575-7489
1003 12th Street, Butner, NC 27509
Founded 1980
An Equal Employment Opportunity/Affirmative Action Employer
| North Carolina Department of Health and Human Services
| Whitaker Psychiatric Residential Treatment Facility (PRTF) |

| http://www.ncdhhs.gov/dsohf/services/whitaker.htm |
| Telephone: 919-575-7927 General Fax: 919-575-7895 Confidential Fax: 919-575-7489 |
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An Equal Employment Opportunity/Affirmative Action Employer
3. **DIAGNOSTIC INFORMATION**

**DSM-V Diagnoses/Date of Diagnosis:**

--------------------------------------------------------------------
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**Previous DSM-IV Diagnoses of Concern:**

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**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 that the applicant would benefit from the program. A referral to the STARS program at Murdock is recommended.*

VCI______ PRI______ WM_______ PS_______ FSIQ _______ Date ___________

**Adaptive Behavior Scales (if any):** __________________________________________

**Substance Use/Abuse History:** __________________________________________

**Sexual Offense/Abuse History:** __________________________________________
Gang Affiliation if any: __________________________________________________________}
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
## Primary Symptoms/Behaviors (check all that apply)

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>If yes, describe</th>
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<tbody>
<tr>
<td>Psychotic</td>
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<td>Assaultive</td>
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<td>Destructive</td>
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<td>Suicidal or Self-Destructive</td>
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<td>Runaway Tendencies</td>
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<tr>
<td>Sexual Acting Out</td>
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<tr>
<td>Substance Abuse</td>
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<tr>
<td>Other</td>
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</table>

**Strengths/Assets:**
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Medical Problems**
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

**Current Medications (Dosage)**
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
4. ECOLOGICAL INFORMATION

***NOTE: EACH STUDENT 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. ***

Plan/Identification/Description of Visiting Resource: ________________________________
______________________________________________________________________________
______________________________________________________________________________

Plans for transportation to and from Visiting Resource: ______________________________
______________________________________________________________________________
______________________________________________________________________________

Discharge Plan - Whitaker PRTF prepares students to live in less restrictive environments on discharge. However, the problems of our students are more severe than most. They continue to need intense services (although not in a locked facility) after they leave Whitaker. Please be specific and detailed about the child’s program at discharge: ________________________________
______________________________________________________________________________
______________________________________________________________________________

Parental/Family Involvement:

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

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

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 area program provide while the applicant is in Placement? __________

__________________________________________________________________________________

__________________________________________________________________________________

Signature: ___________________________  Date: __________
Person Making Referral

Signature: ___________________________  Date: __________
COC Representative
Additional Information (Please attach information behind this page)
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: Intellectual and Developmentally Disabled students 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 3 years of the referral is mandatory. The entire report is preferred.)

*_______ Psychosocial Assessments
*_______ Psychological Testing Including IQ Testing (within the last 3 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 and/or 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 BED, L/D, 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.
North Carolina Department of Health and Human Services
Whitaker Psychiatric Residential Treatment Facility (PRTF)

* ______ 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 Person Centered Plan which includes: Goals, Strengths, and Weaknesses.

_______ DSS Reports (if applicable)

_______ Juvenile Court Reports (if applicable)

_______ Staffing Notes from the Collaborative Meeting

_______ Other______________________________________

_______ Other______________________________________