North Carolina Department of Health and Human Services
Whitaker Psychiatric Residential Treatment Facility (PRTF)

Pat McCrory
Governor

Richard O. Brajer
Secretary

Walter Ed Beal, Jr.
Chief Executive Officer

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.

Treatment Intervention/Placement	**Dates**	**Applicant Response**

:

:

3. **DIAGNOSTIC INFORMATION**

DSM-V Diagnoses/Date of Diagnosis: _____

_____

_____

_____

_____

_____

Previous DSM-IV Diagnoses of Concern:

_____

_____

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: _____

_____

_____

_____

:

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

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Primary Symptoms/Behaviors (check all that apply)

	Yes	No	Unknown	If yes, describe
Psychotic	☐	☐	☐	
Assaultive	☐	☐	☐	
Destructive	☐	☐	☐	
Suicidal or Self-Destructive	☐	☐	☐	
Runaway Tendencies	☐	☐	☐	

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Sexual Acting Out	☐	☐	☐	
Substance Abuse	☐	☐	☐	
Other	☐	☐	☐	

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

:

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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.

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*_____ 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_____

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