SC CHILDREN'S SERVICES UNIVERSAL REFERRAL APPLICATION, Page 1

Date of Referral: _____ Date Placement or Service Needed:

Reason for Referral/Statement of Need (Explain client's problems and needs, and include an estimate of the severity and urgency of the client situation. Attach additional page as necessary):

Requested Service or Placement:

CLIENT INFORMATION

Client Name: _ AKA/Nickname: _____

SSN (last four digits): Medicaid Number: _ Age: _____

Birth date: _____ Gender: _____ Height: __ _____ Weight: __ ___

County of Legal Residence/Custody: _____ US Citizen? __Y__ Legal Immigrant?____

Current Placement/Location: __ LOC: _____

PARENT/GUARDIAN/RESPONSIBLE PARTY

Name: ___ Relationship to Client: _____

Address: _____
phone: _____
Fax: _____
E-mail: _ _____

REFERRING PARTY

Name: _____ Relationship to Client:
Address: _____
Phone: _____ Fax: _____
E-mail:

Note: Placement and/or service authorization is not reimbursable unless formally approved by an authorized employee of the referring agency.

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Other Involved Agencies: _____

Client Name: _____

CLIENT STRENGTHS

Strengths: (Check all that apply)

- ☐ Strong Family Support
- ☐ Appropriate Reading Level
- ☐ Resiliency/Coping Skills
- ☐ Interests_____
- ☐ Religious Affiliation/Preference
- ☐ Other Personal Support
- ☐ Average/Above IQ
- ☐ Good Socialization Skills
- ☐ Interests_____
- ☐ On Grade-Level
- ☐ Good Verbal Skills
- ☐ Good Personal Hygiene
- ☐ Other _____

_____

CLIENT PROBLEMS (Check all that apply, **indicating whether a problem is Current (C), within the last three months, or in the Past** (**P**), and the **frequency or severity rating (SR)** of the issue – **1 = Not too frequent or serious; 2 = moderately frequent or serious; 3 = very frequent and/or severe**. You must describe or explain all items checked, in the space below the chart.):

C	P		SR	C	P		SR
☐		Abandonment/Attachment Issues		☐	☐	Aggressive (Physical)	
	☐	Aggressive (Verbally)		☐	☐	Alcohol/Drug Use	
☐		Anxiety		☐	☐	Arson/Fire Setting	
☐	☐	Attention Seeking		☐	☐	Chaotic Home Situation	
☐	☐	Delusional		☐	☐	Destroys Property	
☐	☐	Mild Depression/Sadness		☐	☐	Moderate/Severe Depression	
☐	☐	Difficulty with Authority		☐	☐	Developmentally Delayed	
☐	☐	Encopresis		☐	☐	Fire Setting	
☐	☐	Eating Disorder		☐	☐	Hyperactive	
☐	☐	Lies/Not Truthful		☐	☐	Loss/Grief Difficulties	
☐		Low self-esteem		☐	☐	Oppositional/Defiant	
☐	☐	Phobic Reactions/Behavior		☐	☐	Physical/Medical Conditions (specify)	
☐		Poor Personal Hygiene		☐	☐	Problems with Walking	
☐	☐	Poor Social Skills		☐	☐	Problems at School	
☐	☐	Self-Destructive Behavior		☐	☐	Sexually Inappropriate	
☐	☐	Sibling Related Difficulty		☐	☐	Suicidal Gestures/Attempts	
☐	☐	Steals		☐	☐	Truancy	
☐	☐	Needs Protection from Others		☐	☐	Unruly/Ungovernable	
☐	☐	Aggressive (Sexual)		☐	☐	Poor Coping Skills	
☐	☐	Antisocial/Criminal Behavior		☐	☐	Poor Reality Orientation	
☐	☐	Autism/Autism Spectrum		☐	☐	Running Away	
☐	☐	Cruelty to Animals		☐	☐	Sexually Provocative	
☐	☐	Expelled/Not in School		☐	☐	Adjudicated/Convicted Sexual Offender	
☐	☐	Manic/Mood Swings		☐	☐	Suicidal Ideation	
☐	☐	Enuresis/Bedwetting		☐	☐	Trust Issues	
☐	☐	Functionally Illiterate		☐	☐	Victim of Neglect	
☐	☐	Impulsive		☐	☐	Victim of Physical Abuse/Violence	
☐	☐	Manipulative		☐	☐	Victim of Sexual Abuse	
☐	☐	Parental Neglect Issues		☐	☐	Victim of Emotional Abuse	
☐	☐	Language Limitations		☐	☐	Wheelchair/Adaptive Devices	
☐	☐	Gang Involvement		☐	☐	Other (specify	
☐	☐			☐	☐		

Explanation (attach additional pages and documentation as necessary):

Note: Placement and/or service authorization is not reimbursable unless formally approved by an authorized employee of the referring agency.

Client Name: _____

PLACEMENT HISTORY (Attached)

Number of Previous Placements: Please list all placements **in past 3 years**, including periods of incarceration and psychiatric hospitalizations. Attach additional pages as necessary or desired.

Placement History			
Name & Type of Placement (Beginning with current placement)	**Start Date**	**End Date**	**Reason For Move**

MEDICAL INFORMATION

CURRENT DIAGNOSES – ICD-9 or DSM IV-TR (list past diagnoses if relevant):

Axis	**Diagnosis**	**Date Given**	**Source**
I			

MEDICATIONS (List all **current** medications, dosages, and instructions. Attach additional page if needed):

Medication Name	Dosage	Instructions

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Client Name: _____

MEDICAL INFORMATION (continued)

Client's Primary Physician: Phone:

Date of Last: Physical Exam: Dental Exam: Eye Exam:

Allergies

Special Dietary Needs:

List any current or prior medical conditions, physical disabilities, adaptive devices, or specialty medical care that a provider needs to accommodate.

SCHOOL INFORMATION

Official Home School District (where parent/guardian/custodial agency resides):

Is the client currently attending any school? **Yes** ☐ **No** **If NO**, why not: _____

Is the client currently functioning on grade level? **Yes** ☐ **No** Comments: ____She functions on level, but she is not on grade level_____

List last five schools attended, beginning with the current/most recent school:

SCHOOL ATTENDED	DATES		GRADE	COMPLETED?

Has client ever been classified Special Education? ☐ **UNKNOWN** **NO** ☐ **YES**

IF YES, primary classification: _____ Secondary Classification: _____

Does client have a current IEP?	☐ No	☐ Yes	IF YES, date:
Does client have a section 504 Accommodation Plan?	☐ No	☐ Yes	IF YES, date:
Is client currently under recommendation for expulsion?	☐ No	☐ Yes	IF YES, Explain below:

Explain any school-related problems or conditions needing to be accommodated:

Attach additional information or documentation necessary to make an informed placement decision (including CALOCUS, CBCL, GAIN SS, Psychological, medical or program notes, discharge summaries, etc.).

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