

WRAPAROUND REFERRAL FORM

Child's Name:		SS#:	Date of Referral:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Date of Birth (Month/Date/Year):		Age:
Address:				
<small>(Street or PO Box)</small>	<small>(City)</small>	<small>(State)</small>	<small>(Zip Code)</small>	
Phone: (Home)	(Cell)	(Message)	Email address	
County of Residence:		Grade:	School:	
Parent(s)/Guardian(s) Name:		Guardian, list relationship:		
Child's primary language:		Parent(s) primary language:		
Medicaid/ARKids 1 st Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid #:	Private Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child involved in mental health services: <input type="checkbox"/> Yes <input type="checkbox"/> No: If yes, name of agency:				
List child's mental health diagnosis/diagnoses (if any):				
Child takes medication(s) for mental health issues: <input type="checkbox"/> Yes <input type="checkbox"/> No: If yes, name of medication(s):				
Child receives Supplemental Security Income (SSI): <input type="checkbox"/> Yes <input type="checkbox"/> No			Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please select all options below that best describe the child you are referring: if none of the options describes the child then check "not applicable".

A child/youth is under the age of 18 or a youth is between 18-21, who receives behavioral health services prior to the 18th birthday.

1) Living Arrangements

- Both parents (biological, step, adoptive)
- Single parent
- Relative: Specify: _____
- Out of home (foster care or non-relative)
- Not Applicable

2) High risk of out of home placement

- Currently at risk for out of home placement in a residential facility for behavioral or psychiatric issues
- Previous out of home placement
- Not Applicable

3) Suicide Attempts

- History of one or more suicide attempts within the last 12 months
- Not Applicable

4) Dangerous Behaviors

- Demonstrated a danger to self or others within the last 6 months
- Engaged in serious or repeated acts of destruction to property within the last 6 months
- Is self-destructive such as at risk for suicide, runaway, promiscuity; or at risk for causing serious injury to others
- Not Applicable

5) Child is involved in:

- Multiple school, church or community activities
- One extracurricular school activity, club or sport
- No activities outside of the home

6) Substance abuse:

- Current substance abuse
- Previous substance abuse
- Not Applicable

7) Current Court Involvement within the last 12 months

- FINS
- Delinquency
- Custody/Adoption
- Protective Service/DCFS
- Diversion
- Not Applicable

8) Current DCFS Involvement

- Supportive Case
- Protective Service Case
- Intensive Family Services
- Foster Care/Therapeutic Foster Care
- Not Applicable

9) Mental Health Hospitalizations (acute or long term)

- Current hospitalization in inpatient psychiatric hospital
- 2 acute psychiatric hospitalizations within last 12 months
- Not Applicable

10) Recent or pending Discharge from Residential Placement

- Mental Health/Behavioral Health
- Group Home
- DYS
- Not Applicable

11) Functional Impairment or Symptoms

- Impairment in self-care-inability to take care of personal grooming, hygiene, clothes, etc.
- Impairment in community function by lack of age appropriate behavioral controls, judgement, etc.
- Impairment in functioning in social relationships
- Impairment in functioning in the family
- Impairment in functioning in school
- Not Applicable

12) Special Education Needs

- 504 Behavior Plan
- IEP
- Alternative School/Learning Environment
- Other, please explain

13) Sexual Abuse (of referred child)

- Previous child abuse investigation
- Current child sexual abuse investigation
- Child abuse investigation is substantiated/founded
- Child has a history of significant trauma
- Not Applicable

14) Sexual Perpetration (child as offender)

- Child is sexually acting out
- Child currently has pending charges for sexual crime
- Child has been convicted of a sexual crime
- Current/past investigation of sexual perpetration
- Not Applicable

15) Physical Abuse (of referred child)

- Previous child physical/neglect abuse investigation
- Current child abuse investigation
- Child abuse investigation is substantiated/founded
- Child has a history of significant trauma
- Not Applicable

16) Physical Violence

- Child has been physically harmed in some way
- Child has witnessed physical harm of other person(s)
- Child has been bullied in school or community setting
- Child has a history of significant trauma
- Not Applicable

17) Physical Aggression

- Past physical aggression
- Has bullied kids at school
- Has been involved in gang activity
- Current physical aggression
- Not Applicable

What is the primary reason for referring this child/adolescent for a Wraparound?

Please list any medical or developmental concerns for the child/adolescent being referred:

Please describe the strengths of the child/youth and the family and any additional comments:

Any additional information that would be helpful (Include any risk for out of home placement):

Name of person completing the referral:		Relationship to child:	
Agency referral:		Parent/Guardian referral:	
Address:			
(Street or PO Box)	(City)	(State)	(Zip Code)
Phone: (Home/work):	(Cell):	(Email):	
Are you willing to participate in the Wraparound team meetings for this child/adolescent you are referring? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has family given permission to be referred for service? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please List any suggestion for Team members:			

For Office Use Only

Date Referral Received _____ Received by: _____

Program Eligibility: CCCCY Yes No

CASSP Yes No

External Referral Made: Yes No To whom was referral made & date _____