Travis County CRCG

CRCG Referral Form

Thank you for partnering with us to support children and families in Travis County. Please use discussion with the family, gathered assessments, treatment records, and contacts with the child's current providers to answer all questions. The more details we have the better likelihood of being able to identify available programs and services.

Child/Youth & Family Information

Date: _____

Child/Youth Name: _____ Date of Birth: _____

Referral Information

Referral Source/Agency _____

Person Completing Referral: _____

Contact Info (Phone #/Email): _____

Reason for Referral - Summary of and Behaviors of Concern and History of Events:

_____

_____

_____

_____

_____

_____

_____

_____

Child & Family Strengths:

_____

_____

_____

What services and supports would benefit the child and family?

_____

_____

Details of Child's Complex Needs & Reason for Referral

(mental health, intellectual/developmental and/or medical needs)

History of Documented Diagnoses (required to determine eligibility for most services)

Please only list documented diagnosis and attach copy of evaluations and/or documentation

Current Diagnoses	Diagnostician	Date of Evaluation

Past Diagnoses (ruled out or no longer considered true)

Past Diagnoses	Amount	Year/Date Prescribed

History of Medications

Current Prescribed Medication	Dosage	Year/Date Prescribed	Prescribing Physician

Past Prescribed Medication	Year/Date Ended	Prescribing Physician	Reason Discontinued

Agency and Treatment Involvement

Integral Care Involvement (Past & Present): ☐Yes ☐No

- ☐ **PES: Psychiatric Emergency Services Clinic** ☐ **MCOT: Mobile Crisis Outreach Team**

Date(s) of services and outcomes: _____

_____

- ☐ **Child & Family Services (behavioral health):**

Contact Person (Email/Phone#): _____
Enrollment Date: _____ Current Level of Care: _____
Services Provided: ☐Therapy (☐ Clinic or ☐ School Based) ☐Psychiatric/MEDS ☐YES Waiver
History w/ CFS Services (List current & prior involvement w/ dates and outcomes):

_____

_____

_____

_____

And/Or

- ☐ **Intellectual & Developmental Disabilities:**

Contact Person (Email/Phone#): _____
Enrollment Date: _____ Current Level of Need: _____ DID Completed: _____
Services Provided: ☐General Revenue ☐Medicaid Waiver Services ☐ Crisis Services

☐ Other: _____

History w/ IDD Services (List current & prior services w/ dates and outcomes):

_____

_____

_____

_____

Other Counseling/Behavioral Health Treatment and Therapy (Past & Present):

☐Yes ☐No - If yes, please list agency(s) w/ dates of involvement, services, and current contact information:

_____

_____

_____

_____

_____

_____

Other Developmental Treatment, Therapy, & Supports (Past & Present): ☐Yes ☐No

(examples: Occupational, Physcial,Early Childhood Intervention, etc)

If yes, please list agency(s) w/ dates of involvement and current contact information:

_____

_____

_____

_____

History of Intensive & Out of Home Treatment

Residential Treatment Center(s), Hospitalization(s), PHP & IOP - *attach discharge paperwork*

1. Facility: _____ Admit Date: _____ End Date: _____
   Reason for Admission: _____
   _____
   Discharge Details & Plan: _____
2. Facility: _____ Admit Date: _____ End Date: _____
   Reason for Admission: _____
   _____
   Discharge Details & Plan: _____
3. Facility: _____ Admit Date: _____ End Date: _____
   Reason for Admission: _____
   _____
   Discharge Details & Plan: _____
4. Facility: _____ Admit Date: _____ End Date: _____
   Reason for Admission: _____
   _____
   Discharge Details & Plan: _____
5. Facility: _____ Admit Date: _____ End Date: _____
   Reason for Admission: _____
   _____
   Discharge Details & Plan: _____

School Information

Summary of school related needs, behaviors and challenges: _____

_____

_____

_____

School District Child/Youth Attends: _____ Grade: _____

Name of School: _____

School Contact Person (w/ email/phone#): _____

If child not attending home campus zoned for child's residence, is placement related to any of the following:

☐Discipline ☐Specialized Services for Special Education ☐Family Requested Transfer ☐Other:

_____

Has Child/Youth ever been suspended or served at their district's Alternative Discipline Campus? ☐Yes ☐No

Details: (dates, reason, etc) _____

_____

Does child receive any additional school-based services? (choose only one):

☐No Additional Services ☐ Special Education ☐ 504 Accommodations ☐ Parent Request/Referred for Special Education ☐ Parent Request Pending for 504 Accommodations

Details of 504 Accommodations (if applicable): _____

_____

Details of Special Education Services (if applicable):

Special Education Eligibilities(s) (chose all that apply):

☐AU (Autism) ☐ID (Intellectual Disability) ☐LD (Specific Learning Disability) ☐ED (Emotional Disability)

☐OHI (Other Health Impairment): _____

☐Speech Impairment ☐Deaf/Hard Hearing ☐Deaf/Blindness ☐Traumatic Brain Injury

☐ Visual Impairment ☐Developmental Delay ☐Multiple Disabilities ☐Non-Categorical Early Childhood

☐Orthopedic Impairment

Date of last ARD: _____ (or next scheduled ARD: _____)

Completed Assessments:

☐Full Individual Evaluation (FIE) (Date Completed: _____)

☐Behavior Intervention Plan (BIP) ☐Functional Behavioral Assessment (FBA)

Classroom Status of Child/Youth: ☐Self-Contained ☐ Inclusion ☐ Resource Classes

Does child receive 1:1 Aid Support? ☐Yes ☐No

Related Services Provided by the School: ☐Occupational Therapy ☐Physical Therapy ☐Speech Therapy

☐Assisted Technology ☐Counseling as a Related Serive

Additional Systems/Agency Involvement

Please list ALL PAST and PRESENT involvement with below systems and/or agencies:

Law Enforcement Involvement (Past & Present): ☐Yes ☐No

☐ Juvenile Justice ☐ Adult Criminal Court Services ☐ Law Enforcement Contact (No Charges Filed)

Juvenile Probation Officer (Email/Phone#): _____

Type of Probation: ☐ Conditions of Release (Pre-Trial) ☐ DPU ☐ COPE ☐ Judicial Confession ☐ SNDP ☐ Probation ☐ ISP ☐ SOAR

Date of Referrals: _____

Upcoming or Most Recent Court Date: _____ Expiration Date: _____

Assessments Completed by TCJPD: ☐Mental Health Assessment ☐Psychological

History and Events Involving Law Enforcement (list dates and outcomes):

_____

_____

_____

_____

Dept. of Family & Protective Services - (Past & Present): ☐Yes ☐No
☐ Child Protective Services ☐ Adult Protective Services

Most Recent Referral Date & Status: _____
Contact Person (Email/Phone#): _____
History with Agency (dates and outcomes):

_____

_____

_____

_____

Travis Co. Health & Human Service Programs & Partnerships (Past & Present): ☐Yes ☐No

☐ Community Center (location): _____

☐ Emergency Services (Food, Rent Asst) ☐ Deaf Services ☐ Healthy Families ☐ Family First

☐ YFAC-Communities in Schools Service Coordination ☐ CRCG Meeting ☐ CPS Reintegration

☐ The Children's Partnership ☐ Parents in Recovery (PIR)

_____

_____

_____

_____

Please list ALL Community Resources and Activities this family has participated in with dates of involvement: (Examples: Social Groups, Faith-Based, Recreation Programs, Mentors, Coaches, Non-Profits, etc.)

_____

_____

_____

_____

_____

Additional Out of Home Placement Information

Other (i.e. foster, non-profit placement, relative placement, shelter):

1. Agency/Person Name: _____ Begin Date: _____ End Date: _____
   Type of Service: _____
   Outcome: _____

2. Agency/Person Name: _____ Begin Date: _____ End Date: _____
   Type of Service: _____
   Outcome: _____

3. Agency/Person Name: _____ Begin Date: _____ End Date: _____
   Type of Service: _____
   Outcome: _____

4. Agency/Person Name: _____ Begin Date: _____ End Date: _____
   Type of Service: _____
   Outcome: _____

Please remember to have the child or youth being referred complete the

Child/Youth Interest Form