REFERRAL FORM- CHILD/YOUTH CRISIS RESIDENCE SUPPORT PROGRAM

17 Wells Street Plattsburgh, NY 12901
Phone: 518 557 4500 Email: crisisreferrals@bhsn.org

Basic Client Information	**Referral Date:**
Legal Name:	Preferred Name:
Parent/Guardian Name:	
(Physical) Address:	
County of Residence:	SSN#:
Phone #:	DOB:
Primary Language:	Ethnicity:
Child/Youth School:	
Pediatrician/Primary Care Doctor:	

Financial Information			
Insurance Policy:		Policy ID:	
Policy Holder Name:		Medicaid #:	
Policy Holder DOB:		Medicare #:	

Referral Information (Please ensure to give direct contact lines, for streamlined communication)	
Individual Making Referral Name:	
Representing which Agency/Hospital:	
Address:	
Phone:	
Fax:	
Email:	

Mental Health History	
Current Mental Health Treatment? (Where)	
Treatment Compliance/ Engagement?	

Current Medications?	
Inpatient Hospitalizations (Where, Dates of last 90 days, why?)	
Health Home Care Management? Community residence/supported housing?	

Known Risk Factors:	**Present** within 14 days	**Past** More than 14 days ago	**No known History**	Comments- must include most recent date, details, and impact
Suicidal (Ideation, attempts) *Include most recent Columbia*				
Elopement				
Violence				
Physical Harm to others				
Destruction of Property				
Fire Setting				
Sexually abusive				
Incarceration				
Outbursts				

Command Hallucinations				
Drug/alcohol abuse				
Frequent Crisis Contacts				
Major or Multiple Medical Problems				
PINS Program				
Poor School Attendance/ Suspensions/Disciplinary				
Non-Suicidal Self Injurious Behavior				

Independent ADLs to include:	**Yes**	**No**	**Limited with Support**	**Identify Support needs to accomplish ADL**
Toileting				
Feeding				
Bathing				
Evacuating in Emergency				
Dressing				
Taking Medication				
Medical Needs				

Crisis Respite Need
Current acute psychological/emotional change:
Client's current resources/supports:

Current symptoms of distress:	
How are current impairments in mood/thought/behavior impacting home, school or the community?	
What treatment services have been attempted to aid in managing the above distress so far and what was the client and family's response?	
Goal for Crisis Respite:	
Are Parent/Family Supports aware of Referral?	
In agreement with referral?	
Is Child aware of referral?	
In agreement with referral?	
Referral does not guarantee placement, and this has been communicated to Parent and Child?	
Are Parent/Family Supports willing to actively engage in services to include crisis respite?	
Discharge Location:	

** ALL Referrals will be reviewed by the Program Director and/or Program Coordinator **

Signature of Referral Source: ____________________ Date: ____________________

Reviewed By: ____ Date: ________________________________

Referrals should be sent to crisisreferrals@bhsn.org and they will be reviewed by the Program Director and/or Program Coordinator within 72 hours. If the need is urgent, please send a referral via email and then contact Mobile Crisis via 1-866-

577-3836. The Mobile team will review with Program Director and/or Program Coordinator upon receipt. *Additional documents can be faxed as needed to 518-563-3704.*