



INTAKE SERVICES HIGHER LEVEL OF CARE REFERRAL
 DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES
 DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES
 1825 Faulkland Road Wilmington, DE 19805 (302) 633-2571 or (302) 633-2591

Please fill out this form as completely as possible and call if you need assistance.

Fax this form to (302) 622-4475 or mail it to the address above or email to:
DSCYF_Intake_General@state.de.us

Date:	Child Name:	DOB:	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Race:	Ethnicity:
Child's Current Address:			
City/Town:	County:	State:	Zip:
Education: : <input type="checkbox"/> Regular Education <input type="checkbox"/> Special Education	School:	Grade:	

****If you are not the parent please include guardianship papers with your referral – failure to do so will result in a delay or possible closure of the case.**

Parent/Guardian Name: _____

Custodian: _____

Address: _____

City: _____ State: _____ Zip _____

Phone: (H) _____ (W) _____

Insurance Information

Active Medicaid: (Delaware Physicians Care, United Health Care, Diamond State Partners)?

Y N

Private Insurance: (Aetna, BCBS, etc.) : Y N

If yes, name of company: _____

Please include a summary of mental health/substance abuse benefits available through your child's private insurance provider

Current Agency Involvement:

DYRS: Y N Worker Name: _____

DFS: Y N Worker Name: _____

DDDS: Y N Worker Name: _____

Court Involvement: Y N

Family Court Mental Health Court Drug Court Truancy Court

Treatment Information

- Is the child currently in mental health treatment? Y N
 - Attending: Weekly Every other week
- Is the child currently in substance abuse treatment? Y N
 - Attending: Weekly or Every other week

If the child is ***not currently*** in any type of outpatient treatment or attending at some other level, please explain why:

If you answered yes to any of the questions above, please fill out the box below for current and previous treatment history.

Treatment history (current and previous)				
Mental Health or Substance Abuse Treatment Provider:	Type of treatment (If known)	When did treatment begin?	End Date?	Was it Helpful?

****If your child is being referred for substance abuse treatment, please seek an outpatient substance abuse assessment prior to completing this referral****

Medical Information

List all serious medical problems:
(Additional documents may be requested)

List all Doctors your child sees:

Current medicine	Dose	Doctor who prescribed

What are your child and family's strengths and interests?



**CONSENT FOR RELEASE OF CONFIDENTIAL
MENTAL HEALTH INFORMATION
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES**

I, _____, authorize
(Print name of youth)

Please check appropriate box:

- | | |
|---|---|
| <input type="checkbox"/> Division of Family Services (DFS) | <input type="checkbox"/> Department of Education (DOE) |
| <input type="checkbox"/> Division of Youth Rehabilitation (YRS) | <input type="checkbox"/> Multi Disciplinary Team (MDT) |
| <input type="checkbox"/> Parent / Guardian | <input type="checkbox"/> Deputy Attorney General's Office (DAG) |
| <input type="checkbox"/> Family Court | <input type="checkbox"/> Public Defender (PD) / Private Attorney (PA) |
| <input type="checkbox"/> Superior Court | <input type="checkbox"/> Other (Please specify): _____ |

To disclose To receive from the Division of Prevention and Behavioral Health Services the following information:

All information pertinent to substance abuse, including verbal communication, treatment progress and assessment, drug screen reports, and discharge summary.

The purpose of the disclosure authorized herein is to: Assist in completion of Prevention and Behavioral Health Services evaluation(s), treatment recommendations, and / or placement.

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I have the right to receive a copy of this form after completing it. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:

THIS AUTHORIZATION WILL EXPIRE SIX (6) MONTHS FROM DATE OF SIGNATURE

_____ Signature of Youth	_____ Print Name of Youth	_____ Date
<i>(mandatory for children 14 years old and older)</i>		

_____ Signature of Parent or Guardian <small>(mandatory if client under 14 years old)</small>	_____ Print Name of Parent or Guardian	_____ Date
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**PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN
ALCOHOL OR DRUG ABUSE TREATMENT**

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with consent of such a client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



**CONSENT FOR RELEASE OF CONFIDENTIAL
MENTAL HEALTH INFORMATION
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES**

Client Name: _____ DOB: _____

I, (Parent/Guardian/Custodian/DFS) _____ hereby authorize the Division of Prevention and Behavioral Health Services (DPBHS) to Release Verbal/Written Information to and to receive verbal and written information from:

Agency name or school: _____

Name of contact person at agency/school (if known): _____

Verbal and written information to be released by DPBHS: (Check all items that apply.)

- Admission / Discharge Summaries (DPBHS services for past 2 years)
- Service Admission Form (includes Demographics, CSM Service Plan, DPBHS Treatment History, Medication History, Risk Factors)
- DPBHS Psychosocial Evaluation DPBHS Psychological Evaluation DPBHS Psychiatric Evaluation
- Educational Records Treatment Progress/Summary
- Most recent physical exam (not to include pregnancy, STD, HIV information)
- Other: _____

The purpose of this information disclosure by DPBHS is to: (Check all items that apply.)

- Make a referral/provide treatment by the clinical treatment organization or person listed above
- Assist in the completion of PBHS Evaluation(s)
- Provide clinical information to organization or person named above

Verbal and written information to be released to DPBHS: (Check all items that apply.)

- Initial Evaluation Comprehensive Treatment Plan Discharge Summary
- Treatment Progress Summary Physical Examination Speech and Language Evaluation
- Neurological Evaluation Medication History Psychiatric Evaluation
- Most recent educational records including educational testing and school psychological, IEP/IPRD documents, school attendance and behavioral/disciplinary records
- Other _____

The purpose of this information disclosure by the agency/school named above is to: (Check all items that apply.)

- Enable PBHS to Plan, Monitor, Authorize Payment, Coordinate Care with Treatment Provider
- Enable PBHS to use the educational material in planning treatment
- Enable PBHS to collaborate with the school in planning and providing services
- Assist in the completion of PBHS Evaluation(s)

I understand that this form can not be used to release information about drug and alcohol treatment, pregnancy, HIV status, and sexually transmitted diseases.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Director of Quality Improvement in the Division of Prevention of Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this release in order to be assured treatment. I understand that I may inspect or copy the information used or disclosed as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Director of Quality Improvement, Division of Prevention and Behavioral Health Services.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 C.F.R. pts. 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Personal Health Information (PHI) is disclosed, the recipient may re-disclose it, therefore the privacy regulations may no longer protect it.

This authorization is valid for one year from the signature date unless revoked.

Parent, Guardian, Custodian, DFS Signature (Circle one)

Print Name/Date

DSCYF Representative Signature

Print Name/Date

DIRECTIONS:

Please consider the problems that your child is having when filling out the form below. Please think about your child's age and developmental level when answering the questions. If the problem applies to your child please check the most appropriate box. In some cases it will be appropriate to check both boxes. That is okay. If the problem has never happened please leave the box blank.

CHILD'S HISTORY	In last 30 Days	Ever
1. Suicidal thoughts/threats		
2. Suicidal gestures		
3. Suicide attempts requiring hospitalization		
4. Injures self, e.g., cutting, head-banging, burning, picking skin		
5. Homicidal – Statements of killing others		
6. Physically violent – Physically hurting others		
7. Verbally threatening - Threatening to hurt others		
8. Frequent, intense, uncontrollable temper tantrums		
9. Hallucinations (sees or hears things that aren't there)		
10. Delusions (has strong beliefs which have no basis in reality)		
11. Cruel to animals		
12. Willful destruction of property		
13. Fire setting		
14. Victim of physical Abuse confirmed/suspected		
15. Victim of Sexual Abuse confirmed/suspected		
16. Victim of Emotional Abuse confirmed/suspected		
17. Suspected or confirmed victim of caregiver neglect, e.g. failure to provide food, shelter or clothing.		
18. Inadequate or inappropriate parental supervision and/or discipline		
19. Exposure to Domestic Violence		
20. Wetting or Soiling (after potty training)		
21. Overly sensitive to environment (noise, touch) which causes distress		
22. Difficulty separating from parents, school refusal		
23. Recurrent intrusive thoughts or repetitive behaviors, such as hand washing, lock checking, organizing objects		
24. Persistent unrealistic worry over physical health		
25. Avoids people, places or things		
26. Always seems jumpy or afraid		
27. Gets upset when remembering bad thing that have happened to him/her.		
28. Many nightmares		
29. Child has experienced traumatic event, e.g. flood, hurricane; frightening medical procedure; being or seeing someone severely injured (accident or assault); seeing a dead body or someone killed.		
30. Psychosocial stressors, e.g., death, absence or loss of significant person in child's life and/or multiple life changes, serious illness in family, economic problems		
31. Instability of residential arrangement, e.g., homelessness, multiple placements, frequent relocations		
32. Problems with same age peers		
33. Problems with family relationships or relationships with authority figures		
34. Inability to give or receive appropriate affection to primary caregivers		
35. Arrested, detained, or on probation		
36. Gambling		
37. Inappropriate sexual activity		
38. Running away		
39. Suspected or confirmed abuse of alcohol or other drugs/substances		
40. Confirmed or suspected developmental/Intellectual delay		

41. Problems in school/vocational activity (attendance, behavior, performance)		
42. Difficulty in concentration		
43. Excessive sadness, crying, withdrawal		
44. Easily angered or excessive anger.		
45. Excessive irritability		
46. Excessive fears or worries		
47. Irregular or problematic eating/appetite patterns		
48. Medical condition complicated by emotional disturbance or medical noncompliance		

FAMILY HISTORY						
PROBLEM	Mother	Father	Guardian	Sibling	Grandparent	Other
1. History of Self Harm - i.e. Cutting, Burning						
2. Attempted Suicide						
3. Completed Suicide						
4. History of Mental Health Issues						
5. Current Mental Health Issues						
6. History of Substance Abuse						
7. Current Substance Abuse						
8. History of Incarceration						
9. Current Incarceration						
10. Domestic Violence						

Submission of this form does not constitute a formal abuse report. Mandated reporters are legally obligated to report suspected child abuse or neglect to DFS at 1-800-292-9582.

Any other problems not mentioned above:

Completed By: _____ Date _____

Agency/Position _____ Telephone _____

***Please note, DPBHS Intake will call you to confirm receipt within 1 business day of receiving the referral. If you do not hear from us, please contact us at 633-2571 or verify the information was sent to the fax number/address indicated on the first page of the referral.**