

Behavioral Health System Baltimore
RESPIRE REFERRAL FORM

AGENCY INFORMATION

Referral Date: _____ Referral Agency: _____

Phone #: _____

Name/Position of Person Completing this form: _____

Relationship to Child/Adolescent: _____

Email address of referring therapist: _____

Reason for Referral: _____

Describe emotional and/or behavioral problems which stress the ability of the caregiver to provide for the individual in the home: _____

What is the source of the referral information (i.e. clinical record, interview with parent, school record, etc.)? _____

Type of Respite Requested (Check One): In-home community.
 Out of home*

*If out-of-home respite is requested, will the parent/guardian be able to assist with transporting the child/adolescent to and from the respite location/home, school, and other activities? Yes No

How often is respite being requested for? _____

CHILD/ADOLESCENT INFORMATION

Name: _____ Date of Birth: _____

Sex: Male Female Race: Caucasian African American Other _____

SS #: _____

MA #: _____

Insurance: _____

Policy #: _____

Child currently resides with: Parents Mother Father Other _____

Address: _____

Phone #: _____

List household members/relationship/age

Member	Relationship	Age

Legal Custody/Guardianship:

Address: _____

Phone #: _____

Medical Guardianship:

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Address: _____

Name of School: _____ Grade: _____
Current Level of Education: Regular Education Special Education 504 Plan

IQ Information:

Verbal: _____ Performance: _____ Full Scale: _____ Not Available

Name/Address of Current Mental Health Provider(s):

Most Recent Diagnosis:

Behavioral Diagnoses

Primary Diagnostic Category

Diagnostic Category 1

Diagnostic Category 2

Diagnostic Category 3

Primary Medical Diagnosis

Diagnostic Category

Diagnostic Category

Diagnostic Category

Social Elements Impacting Diagnosis

Functional Assessment

Assessment Measure: _____ Assessment Score: _____

Medications: None

_____	_____
_____	_____
_____	_____

Please explain how daily life activities are compromised:

Please explain any other stresses on the caregiver that may put the individual at risk for out-of-home placement or a higher level of care:

Individual Treatment Plan (ITP) goals related to RESPITE Care Services:

- 1.
- 2.
- 3.

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Previous Placements: Information Not Available

	<u>Date</u>	<u>Agency</u>
Therapeutic Foster Care	_____	_____
Therapeutic Group Home	_____	_____
Diagnostic Center	_____	_____
Shelter Care	_____	_____

	<u>Date</u>	<u>Agency</u>
Psychiatric Hospital	_____	_____
Residential Treatment Center	_____	_____
Detention Center	_____	_____

Other Agency Involvement/Relationship: (check all that apply)

- DSS DJS LEA DDA MHA
 Other _____

Problematic Behaviors/Concerns: (H/O = History of; A= Active)

H/O	A		H/O	A		H/O	A	
		Abandonment issues			Oppositional/Defiant			Property Destruction
		Anxiety			Phobia			Runaway
		Depression			Psychosis			School Problems
		Eating disorder			Self-Mutilation*			Sexually aggressive*
		Enuresis			Suicidal*			Sexually provocative*
		Hyperactive			Alcohol Abuse			Theft
		Impulsive			Drug Abuse			Verbally aggressive*
		Lying			Cruelty to Animals*			Peer difficulties
		Mood fluctuations			Fire setting*			Hallucinations
		Parental addictions			Domestic Violence			Seizures
		Physical Abuse			Sexual Abuse			Neglect

Other:

Please provide where the behavior has been observed, intensity, frequency and date of last occurrence for any items marked with an *.

Allergies, Reactions, and Treatment (medicine, food, insect, and plant):

Physical/emotional health problems that the respite provider should be advised of:

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Signature (person completing the form)	
	Date

<p>By signing below, I hereby give Behavioral Health System Baltimore. permission to release this application and other clinical and psychos-social history to a Respite Program in order to assess my eligibility for respite services for my child I understand that this information will not be released to any other party without my express written consent.</p> <p>I further understand that my consent does not commit me to accept a placement and it does not commit the Core Service Agency to provide a placement for me.</p> <p>I understand that I may revoke this consent at any time by a written statement. This consent is valid for 12 months from the date of my signature.</p>	
Parent or Legal Guardian	Date

BHS Baltimore OFFICE USE ONLY

PRELIMINARY RESPITE PLAN

- Referred for In-Home Respite Service

- Referred for Overnight Respite Services

BHSB Staff Signature	Date
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Please return/fax to:
Behavioral Health System Baltimore
100 S. Charles Street; Tower II; 8th Floor
Baltimore MD 21201
Attn.: Child & Family Programs
Phone number: 410-637-1900
E-Mail: CAYA@BHSBaltimore.org
Fax: 410-637-1906