

**YOUTH CRISIS UNIT - Youth Crisis Stabilization Referral Form** Date \_\_\_\_\_

**Referral Source:** \_\_\_\_\_ Phone Number \_\_\_\_\_

**Client Name:** \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

**Client Placement:** \_\_\_\_\_ Sex \_\_\_\_\_ Heritage \_\_\_\_\_

**Client Social Security Number:** \_\_\_\_\_

**Parents:**

Name \_\_\_\_\_ Phone: Work \_\_\_\_\_

Address \_\_\_\_\_ Phone: Home \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Name \_\_\_\_\_ Phone: Work \_\_\_\_\_

Address \_\_\_\_\_ Phone: Home \_\_\_\_\_

City/State/Zip \_\_\_\_\_

**Dane County Human Services Worker: (if applicable)**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**CCF - CP/ARTT Worker: (if applicable)**

CP/ARTT Casemanager \_\_\_\_\_ Phone \_\_\_\_\_ Pager \_\_\_\_\_

**Mental Health Providers: (if applicable)**

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Therapist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Insurance Coverage:**

Company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Number \_\_\_\_\_ Group Number \_\_\_\_\_

**School:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Other Program: (if applicable)**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Reported history of violent behavior, impulsiveness, suicide threats/attempts:

**ELIGIBILITY CRITERIA**

The child/youth must meet all six (6) of the following conditions:

- 1.  Age 0-20 years of age
- 2.  Dane County resident
- 3.  Emotional/behavioral problems, severe and persistent for at least six months and expected to persist for a year or longer.
- 4.  DSM-IV-R diagnosis from a psychiatrist or psychologist, and/or is eligible for special educational services in school (E.D. or B.D.).

*Diagnosis:* \_\_\_\_\_

*Given by Whom:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Special Education Program:* \_\_\_\_\_

- 5.  Functional Impairment in (2) of the following capacities (compared with expected developmental level). Please check and specify.

Functioning in self care \_\_\_\_\_

Functioning in community \_\_\_\_\_

Functioning in social relationships \_\_\_\_\_

Functioning in the family \_\_\_\_\_

Functioning at school/work \_\_\_\_\_

- 6.  Involvement with (2) or more services from mental health services, social services, special education and law enforcement, and/or juvenile justice system. Please check and specify.

Mental health services \_\_\_\_\_

Social service system \_\_\_\_\_

Child protective services \_\_\_\_\_

Special education \_\_\_\_\_

Law enforcement \_\_\_\_\_

Juvenile justice system \_\_\_\_\_

**ANTICIPATED CRISIS INTERVENTION NEEDS:** Please identify potential crisis that may require intervention. Identify environment, type of crisis, suicide and/or violence risk, etc. Be as specific as possible.