Camelot Community Care, Inc.
Referral Form

Profit Center NF31-17031 Call Date: _____ Client ID Number: _____

Client's Legal Name_____(Guardian:_____)

Home Phone: _____ Cell Phone: _____ Alt Phone: _____

Physical Address _____ Apt # _____

City_____ State _____ Zip _____ County_____

Mailing Address ☐Same as above

Street: _____ Apt # _____

City_____ State _____ Zip _____ County_____

Date of Birth_____ **Gender:** ☐Male ☐Female

Race: ☐Alaskan Native ☐Asian ☐Black/African American ☐Native American Indian

☐Native Hawaiian or other Pacific Islander ☐White ☐Unknown

Ethnicity: ☐Cuban ☐Hispanic ☐Mexican ☐Other Specific Hispanic ☐Puerto Rican ☐Unknown

Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed

Primary Language: ☐English ☐Creole ☐Spanish ☐French ☐German ☐Mandarin ☐Portuguese

Second Language: ☐English ☐Creole ☐Spanish ☐French ☐German ☐Mandarin ☐Portuguese

Needs an Interpreter? ☐Yes ☐No

Military Status: ☐Active Duty ☐Disabled Veteran ☐Discharged ☐None

Social Security Number:_____ If none, explain: _____

Referral: *Date of Referral_____ ☐Emergency Referral

**Referral Source: Name _____ Title _____

Agency _____ Phone _____ Fax_____

Employment Status:
☐Disabled ☐Engaged in Residential/Hospitalization ☐Full Time Employed ☐Part-time Employed
☐Homemaker ☐Inmate of Jail/Prison/Corrections ☐Retired ☐Sheltered Employment ☐Student
☐Volunteer ☐Unemployed but actively looking for work ☐Other/Not in Labor Force ☐Unknown

Occupation: _____ Job Title: _____

Days worked in the past 30 days: _____

Education Level:
Highest Level Completed: ☐Elementary ☐Middle/Junior High ☐High School ☐Not School Age

Comments: _____

Education Type: ☐SED ☐EH ☐Varying Exceptionalities ☐Regular Education
☐Vocational/Job Training, If yes, for how long? ☐In 6 Months ☐In 30 days ☐Unknown
☐Other School

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Household Information: (FFT ONLY)

Annual Household Income: $_____ Individuals in your Household: _____

Individuals under 18 in your household: _____

Principal Income Source: ☐Wages/Salary Income ☐Family/Relative ☐Alimony ☐Child Support ☐Savings/Investment

***Behavioral Concerns per Client, Family or Referral Source** (Mark "H" if issue(s) are historical (over 6 months) and "C" if issue(s) are current); **Indicate ALL that apply**:

Abuse
__Victim of Type:
__Physical
__Emotional
__Sexual
__Excessive Corporal Punishment
__Neglect

__Perpetrator of Type:
__Physical
__Sexual

Anxiety
__Excessive Worry
__Restlessness
__Autonomic Hyperactivity
__Hypervigilance
__Specific Fear_____
__Sleep Disturbance

__Phobia_____
__Obsessive/Compulsive
_____

Self Harmful
__Cutting
__Burning
_____

Psychotic
__ Hallucinations: __A __V
__ Paranoid thinking
__ Delusions

Attention Deficit/Hyperactivity
__Short Attention Span
__Inattentive
__Impulsive
__Easily Distracted
__Failure to Follow through
__Excessive Talking
__Restlessness
__Difficulty Waiting
__Negative Attention Seeking Behaviors
__Risk Taker
__Projecting Blame
__Low Self Esteem
__Poor Social Skills

__Low Frustration Tolerance
__Enuresis
__Encopresis
__Hx of Failure to Thrive
__Fire Setting
__Fire Play
__Gang Association
__Manipulative/Lying
__Learning Disability

Post Traumatic Stress
__Decreased concentration
__"Flashbacks"
__Avoidance of Issue
__Vigilance
__Sleep Disturbances
__Recurrent nightmares

Eating Disorder
__Self-Induced Vomiting
__Use of Laxatives
__Refusal to Maintain Healthy Weight
__Preoccupation w/Body Image
__Irrational Fear of Becoming Overweight

Sexually Inappropriate Behavior
__Touching
__Exposing

Poor Verbal Skills
__Expressive
__Receptive

__Pregnancy
__Physical/Medical issues
_____

Depression
__Sad/Flat Affect
__Irritability
__Isolative/Withdrawn
__Reduced Appetite
__Sleep Disturbances
__Unresolved Grief
__Feeling Hopeless
__Hygiene Problems
__Inactive/low motivation
__Excessive Crying

__Runaway #_____

__Mood Disruption

Oppositional Defiant
__Hostile Towards Adults
__Temper Tantrums
__Constant Arguing w/Adults
__Refusing to Comply
__Blaming Others
__Demanding
__Verbal Aggression/ swearing

Conduct Disorder
__Failure to Comply
__Fighting/Assaultive
__Homicidal
__Intimidation
__Harmful to Animals
__Stealing
__School Maladjustment
__Conflict with Authority
__Risk Taking
__Blaming Others
__Little/No Remorse
__Destruction of Property

Substance Abuse
__Drugs_____
__Alcohol_____

__Suicidal Attempt #_____
__Suicidal Ideation #_____
__Suicidal Gestures#____

***Family Circumstances:**
__Substance Use/Abuse
__Child Custody Issues
__Incarceration
__Domestic Violence
__Low Intellect of Caretaker
__Lack of parental control and/or supervision

☐ **None Identified**
__Financial Issues
__Marital Issues
__Resistant to Treatment
__Single Parent
__Non-English Speaking
__Lack of knowledge of child development and behavior

__Termination of Parental Rights
__Transportation Issues
__Unemployment
__Threatening Hostile Behaviors
__Family history of abuse
__Family history of neglect

__Unwanted Pregnancy
__Ineffective Parenting Skills
__Significant Medical Problems
__Poor communication and/or interactions
__Other _____

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Handicaps/Disabilities At Time of Referral: ☐**None at Referral**

☐Autistic ☐Hearing Impaired ☐Blind ☐Speech Impaired
☐Physically Impaired ☐Deaf ☐Language Impaired ☐Functional Delay
☐Emotionally Disturbed ☐Learning Disability ☐Traumatic Brain Injury ☐Multi-Handicapped
☐MR/Developmentally Delayed ☐Visual Impairment ☐Health Impaired
☐Other_____

Current Medications: _____

Allergies: _____

Program 1: ☐**Outpatient** ☐**In-Home** ☐**In-Home 2 (Lauderdale Only)** ☐**TFC Level:** _____
☐**Foster Care – Texas** ☐**STFC Level**_____ ☐**Comprehensive Assessments**☐**Independent Living** ☐**TIES** ☐**Respite**

Payer Name 1: _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No Ins Number: _____
Authorization Number: _____ Bill to Staff: _____

Payer Name 2 (if applicable): _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No Ins Number: _____
Authorization Number: _____ Bill to Staff: _____

Program 2: ☐**TIES (Lauderdale Only)** ☐**TCM (Clearwater Only)**

Payer Name1: _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No
Authorization Number: _____ Bill to Staff: _____

Records Requested: ☐**NONE**

☐ Physical ☐ Dental ☐ Immunizations ☐ Case Plan ☐Permanency Plan ☐Shelter Order ☐Funding Letter
☐CBHA ☐Birth Certificate ☐Custody Order ☐Other _____

Requested From: _____via ☐ Fax ☐Phone ☐Letter ☐Email ☐In Person

Does the client meet the screening criteria to proceed to Assessment? ☐**Yes** ☐**No** **Date**_____

Date Referral Source Notified _____

If Referral is appropriate--Proceed with Intake Assessment and Complete Below:

Date Assessment Scheduled_____ Time Assessment Scheduled_____

Assessment Scheduled With_____

☐Referral Withdrawn by Guardian and/or Referral source

☐Referral Not Appropriate Due to Exclusionary Criteria: ☐Age ☐Chronic Substance Abuse ☐Chronically Assaultive
☐Needs Higher Level of Care ☐Needs Less Intensive Care ☐Mentally Retarded ☐Actively Psychotic
☐Doesn't Meet Pre-authorization Criteria

Client Referred To_____