CAT Referral Form

Youth Information

Name: _____ **DOB:** _____

Gender: _____ **SSN:** _____

Phone #: _____ **Insurance:** ☐ **CHP** ☐ **BCBS** ☐ **Other:** _____

Address: _____

Main Language(s): ☐ **English** ☐ **Spanish** ☐ **Creole/French** ☐ **Other:** **Translation needed?** ☐ **Yes** ☐ **No**

The individual referred and the family were notified: ☐ **Yes** ☐ **No**

Parent/Guardian Information

Parent or Guardian Name: _____ **Phone:** _____

Check All That Apply:

☐ **This youth has a documented mental health diagnosis:** ☐ **Unsure**

Diagnoses: _____

_____

_____

Current Medications: _____

_____

_____

_____

☐ **This youth has had at least one of the following:**

- ☐ Repeated "traditional" treatment failures **or** in treatment with no progress/worsening
- ☐ Recent history of crisis stabilization unit **or** psychiatric hospital admissions
- ☐ Alternative school placement **or** at risk of "dropping out"
- ☐ Returning home from a residential treatment facility
- ☐ In foster care, but working toward reunification **or** adoption **or** at risk of going into foster care/shelter care
- ☐ At risk of being placed in a Department of Juvenile Justice residential commitment program
- ☐ Other: _____

☐ **This youth has family that is willing to work with the CAT Team.** **Collateral included?**

☐ **This youth has other providers currently working with the family.** ☐ **Yes** ☐ **No**

Whom? _____

Reason for CAT Team Referral (Please explain why the referred individual requires more intensive services and increased level of care including current and previous needs and high risk behaviors):

_____

_____

_____

_____

_____

Indicate ALL other services the referred individual has received for mental health in the past year (list all programs and outcomes as well as all hospitalizations/incarcerations for past year):

Name of Provider/Place:	How Long?	Outcome of Treatment/Placement:

Referrer Information

Name: _____ Phone: _____

Address: _____ Fax: _____

Relationship to youth: _____ Email: _____

Forward Completed Referrals To:

Community Action Team

2634 Capital Circle NE Building B

Tallahassee, Florida 32308

Phone: 850-523-3333 ext. 4105

Email: caloniep@apalacheecenter.org

Fax: 850-523-3499

***** PLEASE INCLUDE COLLATERAL INFORMATION: hospital admission and discharge summaries, medical records, psychiatric evaluations, DJJ, etc. *****

***PLEASE NOTE THAT ADDITIONAL INFORMATION MAY BE REQUESTED PRIOR TO DETERMINATION OF ELIGIBILITY FOR CAT TEAM SERVICES. PLEASE FAX COMPLETED FORM TO CAT AT (850) 523-3499.**