



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 Phone: 850-973-5124 ext. 7346

225 Sumatra Road Email: hillarys26@apalacheecenter.org

Madison, Florida 32340 Fax: 850-973-5128

*** 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.