Required Referral Information

- ☐ Child's demographic Information
  - ☐ Address ☐ Race/Ethnicity ☐ DOB
- ☐ Guardian's Information
  - ☐ Address ☐ Phone Number ☐ Guardianship paperwork (if applicable)
- ☐ Insurance Information
  - ☐ Medicaid ☐ Proof of exhausted benefits (if applicable)
- ☐ Treatment Information
  - ☐ Current diagnosis
  - ☐ Treatment questions
- ☐ Signatures
  - ☐ Page 2 signed by legal guardian
  - ☐ Page 2 signed by child if 14 and older seeking substance abuse treatment

- ☐ Releases
  - ☐ Mental health release completed:
    - ☐ Specifies who (agency/individual) information is to be released to
    - ☐ Signed by child's legal guardian
    - ☐ Appropriate boxes are checked
  - ☐ Drug/Alcohol release (when seeking substance abuse treatment) completed:
    - ☐ Signed by legal guardian (only if child is under 14)
    - ☐ Signed by child if 14 and older
    - ☐ Appropriate boxes are checked
- ☐ Child/Family History Chart (EPSDT)
  - ☐ Chart is filled out correctly and completely

Please note, DPBHS Intake will be using this same form to determine if the referral can be processed. If any of the above information is missing, the case will not be opened for funding until the information is received.

MENTAL HEALTH AND SUBSTANCE ABUSE OUTPATIENT REFERRAL

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES
1825 Faulkland Road Wilmington, DE 19805 (302) 633-2571 or (302) 633-2591

Please fill out this form completely and call if you need assistance.

Fax this form to (302) 622-4475

Date:	Child Name:		DOB:
Gender: ☐M ☐F		Race:	Ethnicity:
Child's Current Address:			
City/Town:	County:	State:	Zip:
Education: : ☐Regular Education ☐Special Education	School:		Grade:

Admit Date:_____ **# of Attended Sessions: _____**

Parent/Guardian Name:_____
Address:_____
City: _____State: ____ Zip_____
Phone: (H)_____ (W)_____

If this is not the parent you must supply guardianship papers

Insurance Information

Active Medicaid: (Delaware Physicians Care, United Health Care, Diamond State Partners)?

☐Y ☐N
If yes, Medicaid # _____

If no, has the application been submitted? ☐Y ☐N

Have sessions been exhausted? ☐Y ☐N
If the Benefits have been exhausted please provide proof (ie EOB, denial, etc.)

Clinical Eligibility

Client's diagnosis (DSM IV including codes):

What is the client being treated for?

What are the treatment goals?

What has been improved upon?

What still needs to be addressed?

I understand that I am applying for DPBHS outpatient services. I attest that the information listed above is correct to the best of my knowledge. I consent to the sharing of information between DPBHS and the treatment provider for funding authorization, treatment planning, and monitoring.

_____ _____

Signature Parent(s)/Legal Guardian/Custodian (circle one) Date

CONSENT FOR RELEASE OF CONFIDENTIAL SUBSTANCE ABUSE INFORMATION DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES

I, _____, authorize
(Print name of youth)

Please check appropriate box:

- ☐ Division of Family Services (DFS)
- ☐ Division of Youth Rehabilitation (YRS)
- ☐ Parent / Guardian
- ☐ Family Court
- ☐ Superior Court
- ☐ Department of Education (DOE)
- ☐ Multi Disciplinary Team (MDT)
- ☐ Deputy Attorney General's Office (DAG)
- ☐ Public Defender (PD) / Private Attorney (PA)
- ☐ Other (Please specify): _____

☐ To disclose ☐ To receive from the Division of Prevention and Behavioral Health Services the following information:

All information pertinent to substance abuse, including verbal communication, treatment progress and assessment, drug screen reports, and discharge summary.

The purpose of the disclosure authorized herein is to: Assist in completion of Prevention and Behavioral Health Services evaluation(s), treatment recommendations, and / or placement.

I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I have the right to receive a copy of this form after completing it. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event, this consent expires automatically as follows:

THIS AUTHORIZATION WILL EXPIRE TWELVE (12) MONTHS FROM DATE OF SIGNATURE

_____ _____ _____
Signature of Youth | Print Name of Youth | Date

(mandatory for children 14 years old and older)

_____ _____ _____
Signature of Parent or Guardian | Print Name of Parent or Guardian | Date
(mandatory if client under 14 years old)

PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with consent of such a client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CONSENT FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES

Client Name:_____DOB:_____

I, (Parent/Guardian/Custodian/DFS) _____hereby authorize the Division of Prevention and Behavioral Health Services (DPBHS) to Release Verbal/Written Information to and to receive verbal and written information from:

Agency name or school:_____
Name of contact person at agency/school (if known):

Verbal and written information to be released by DPBHS: (Check all items that apply.)

- ☐ Admission / Discharge Summaries (DPBHS services for past 2 years)
- ☐ Service Admission Form (includes Demographics, CSM Service Plan, DPBHS Treatment History, Medication History, Risk Factors)
- ☐ DPBHS Psychosocial Evaluation ☐ DPBHS Psychological Evaluation ☐ DPBHS Psychiatric Evaluation
- ☐ Educational Records ☐ Treatment Progress/Summary
- ☐ Most recent physical exam (not to include pregnancy, STD, HIV information)
- ☐ Other: _____

The purpose of this information disclosure by DPBHS is to: (Check all items that apply.)

- ☐ Make a referral/provide treatment by the clinical treatment organization or person listed above
- ☐ Assist in the completion of PBHS Evaluation(s)
- ☐ Provide clinical information to organization or person named above

Verbal and written information to be released to DPBHS: (Check all items that apply.)

- ☐ Initial Evaluation ☐ Comprehensive Treatment Plan ☐ Discharge Summary
- ☐ Treatment Progress Summary ☐ Physical Examination ☐ Speech and Language Evaluation
- ☐ Neurological Evaluation ☐ Medication History ☐ Psychiatric Evaluation
- ☐ Most recent educational records including educational testing and school psychological, IEP/IPRD documents, school attendance and behavioral/disciplinary records
- ☐ Other _____

The purpose of this information disclosure by the agency/school named above is to: (Check all items that apply.)

- ☐ Enable PBHS to Plan, Monitor, Authorize Payment, Coordinate Care with Treatment Provider
- ☐ Enable PBHS to use the educational material in planning treatment
- ☐ Enable PBHS to collaborate with the school in planning and providing services
- ☐ Assist in the completion of PBHS Evaluation(s)

I understand that this form can not be used to release information about drug and alcohol treatment, pregnancy, HIV status, and sexually transmitted diseases.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Director of Quality Improvement in the Division of Prevention of Behavioral Health Services. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this release in order to be assured treatment. I understand that I may inspect or copy the information used or disclosed as provided in 45 C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Director of Quality Improvement, Division of Prevention and Behavioral Health Services.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 C.F.R. pts. 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Once the requested Personal Health Information (PHI) is disclosed, the recipient may re-disclose it, therefore the privacy regulations may no longer protect it.

This authorization is valid for one year from the signature date unless revoked.

_____ _____
Parent, Guardian, Custodian, DFS Signature (Circle one) Print Name/Date

_____ _____
DSCYF Representative Signature Print Name/Date

State of Delaware
Early and Periodic Screening, Diagnosis, Treatment (EPSDT)
Mental Health and Substance Abuse Screen

Child Name:_____ DOB:_____

Completed By: _____ Date:_____

Agency/Position:_____ Telephone:_____

Source of Information:_____

DIRECTIONS:

Please consider the problems that your child is having when filling out the form below. Please think about your child's age and developmental level when answering the questions. If the problem applies to your child please check the most appropriate box. In some cases it will be appropriate to check both boxes. That is okay. If the problem has never happened please leave the box blank.

CHILD'S HISTORY	In last 30 Days	Ever
1. Suicidal thoughts/threats		
2. Suicidal gestures		
3. Suicide attempts requiring hospitalization		
4. Injures self, e.g., cutting, head-banging , burning, picking skin		
5. Homicidal – Statements of killing others		
6. Physically violent – Physically hurting others		
7. Verbally threatening - Threatening to hurt others		
8. Frequent, intense, uncontrollable temper tantrums		
9. Hallucinations (sees or hears things that aren't there)		
10. Delusions (has strong beliefs which have no basis in reality)		
11. Cruel to animals		
12. Willful destruction of property		
13. Fire setting		
14. Victim of physical Abuse confirmed/suspected		
15. Victim of Sexual Abuse confirmed/suspected		
16. Victim of Emotional Abuse confirmed/suspected		
17. Suspected or confirmed victim of caregiver neglect, e.g. failure to provide food, shelter or clothing.		
18. Inadequate or inappropriate parental supervision and/or discipline		
19. Exposure to Domestic Violence		
20. Wetting or Soiling (after potty training)		
21. Overly sensitive to environment (noise, touch) which causes distress		
22. Difficulty separating from parents, school refusal		
23. Recurrent intrusive thoughts or repetitive behaviors, such as hand washing, lock checking, organizing objects		
24. Persistent unrealistic worry over physical health		
25. Avoids people, places or things		
26. Always seems jumpy or afraid		
27. Gets upset when remembering bad thing that have happened to him/her.		
28. Many nightmares		
29. Child has experienced traumatic event, e.g. flood, hurricane; frightening medical procedure; being or seeing someone severely injured (accident or assault); seeing a dead body or someone killed.		

30. Psychosocial stressors, e.g., death, absence or loss of significant person in child's life and/or multiple life changes, serious illness in family, economic problems		
31. Instability of residential arrangement, e.g., homelessness, multiple placements, frequent relocations		
32. Problems with same age peers		
33. Problems with family relationships or relationships with authority figures		
34. Inability to give or receive appropriate affection to primary caregivers		
35. Arrested, detained, or on probation		
36. Gambling		
37. Inappropriate sexual activity		
38. Running away		
39. Suspected or confirmed abuse of alcohol or other drugs/substances		
40. Confirmed or suspected developmental/Intellectual delay		
41. Problems in school/vocational activity (attendance, behavior, performance)		
42. Difficulty in concentration		
43. Excessive sadness, crying, withdrawal		
44. Easily angered or excessive anger.		
45. Excessive irritability		
46. Excessive fears or worries		
47. Irregular or problematic eating/appetite patterns		
48. Medical condition complicated by emotional disturbance or medical noncompliance		

FAMILY HISTORY

PROBLEM	Mother	Father	Guardian	Sibling	Grandparent	Other
1. History of Self Harm - i.e. Cutting, Burning						
2. Attempted Suicide						
3. Completed Suicide						
4. History of Mental Health Issues						
5. Current Mental Health Issues						
6. History of Substance Abuse						
7. Current Substance Abuse						
8. History of Incarceration						
9. Current Incarceration						
10. Domestic Violence						

Submission of this form <u>does not</u> constitute a formal abuse report. Mandated reporters are legally obligated to report suspected child abuse or neglect to DFS at 1-800-292-9582.

Any other problems not mentioned above:

_____
_____
_____
_____

Check one of the following:

A. _____ Child Now has one of the problems listed above, but is currently receiving services to deal with them.
B. _____ Child NOW has at least one of the problems listed above and is not receiving services to deal with them.
C. _____ Child does not NOW have any of the problems listed above according to the screener.

Check one of the following:

A. _____ Child IN THE PAST had one of the problems listed above and has received services to deal with them.
B. _____ Child IN THE PAST had at least one of the problems listed above but has never received services to deal with them.
C. _____ IN THE PAST, child has not had any of the problems listed above according to the screener.

Screener Signature: _____ Date: _____