Children's Mental Health Case Management Referral Form

Please attach the required Diagnostic/Psychiatric/Psychological Assessment that is dated within the last 6 months to this referral form.

Fax to (651) 251-5204

Referral Date: ______________________________

Referent's Information

Name	Agency	Phone	Fax

Child Information

Name	DOB	Current Residence
Race	**Ethnicity**	**Gender**

Have you discussed this referral with the child? ☐Yes ☐ No

Parent/Guardian Information

Name	Relation to Child	Phone	Address

Have you discussed this referral with the child's parent/guardian? ☐Yes ☐ No

Insurance Information

Insurance Company	ID Number	Group Number	Policy Holder

Educational Information

School Name	District	Grade	School Contact Person

Does this child have an Individual Education Plan? ☐ Yes ☐ No

Current Providers

Child Protection	Probation Officer	Therapist	Psychiatrist

Child Protection Services Provided: ____

____

Community Corrections Services Provided:

Therapy Involvement:

Current Medications:

Describe and outline history of community based care:

Describe child's symptoms of mental illness:

Please state need for Children's Mental Health Case Management Services: (Gaps in service delivery system, where and why case coordination may be needed, what you see as advocacy needs, barriers to accessing needed services and other relevant information.)

Severe Emotional Disturbance Criteria

A child must meet criteria of a Severe Emotional Disturbance to eligible for Children's Mental Health Case Management Services

This form needs to be completed by a Mental Health Professional

Child's Name: ___________________________

Date of Severe Emotional Disturbance Determination: ____________________

Emotional Disturbance

To meet criteria for an emotional disturbance the child must have an emotional disturbance, which satisfied both number 1 and 2.

This child has an organic or clinically significant disorder which:

1. Is listed in the DSM-V and was given by a mental health professional.

   ☐ Yes ☐ No

2. Seriously limits the child's capacity to function in aspects of daily living. Fill in the box corresponding to the letter that best describes the child's current functioning.

   ☐ Moderate degree of interference in functioning in most social areas or severe impairment in one area.

   ☐ Major impairment in several areas and unable to function in one of these areas.

   ☐ Unable to function in all areas.

   ☐ Needs considerable supervision.

   ☐ Needs constant supervision.

Severe Emotional Disturbance

To meet criteria for severe emotional disturbance, the child must meet both criteria above and one of the following:

☐ The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance

☐ The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact.

☐ The child has one of the following as determined by a mental health professional:

- ☐ Psychosis or a Clinical Depression
- ☐ Is at risk of harming self or others as a result of an emotional disturbance
- ☐ Psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year.
- ☐ The child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Determination Completed By:

____ _____________________________________

Signature Clinical Supervisor (if applicable)

☐ LICSW ☐ LP ☐ LMFT ☐ MD ☐ RN (with mental health license)