(PLEASE TYPE OR PRINT)

CENTER OF EXCELLENCE
REFERRAL FORM

DATE OF REFERRAL_____ ***(One form per child)*** **TFACTS#**_____

Child _____ **Gender**: ❑ Male ❑ Female
Full Legal Name of Client: (First) (Middle) (Last Name) Alias, if applicable

DOB:_____ **Age**:_____ **County:** _____

Race: ❑Caucasian ❑African American ❑Hispanic ❑Asian/Pacific Islander ❑Other_____
(Please circle one)

Insurance: ❑**TennCare:** United Health Care/BlueCare/Select/Amerigroup ❑**Private** _____ ❑**No Ins.**

Current FSW:_____**Current Supervisor** _____

Is child in custody? ❑**Yes** ❑**No** **Date entered Custody:** _____

If not in custody, is there a high risk of removal? ❑Yes ❑No Why: _____

If noncustodial, describe current and past prevention programs, if applicable: _____

_____

Pending Court Date_____**Type of Hearing (Purpose)**_____**GAL:**_____

Child 's Current Placement Information ***Please circle one*: (GH/RTC/Resource Home/Bio.Parents/Kinship)**

Name/Agency_____**Address/Phone**_____

Level of Placement_____**Placement Contact Person:**_____**Phone #:**_____

MAIN CONCERN: Mental Health:_____**Physical:**_____**Both:(explain)** _____

_____

_____

_____

_____

_____

_____

Check all that apply

- ❑ **Medication concerns**
- ❑ **Conflicting diagnoses and/or recommendations**
- ❑ **Need treatment recommendations**
- ❑ **Multiple placement disruptions**
- ❑ **Severe problem undiagnosed/being missed (mental health and/or physical)**
- ❑ **Barriers to permanency (adoption, subsidy, treatment issues)**
- ❑ **Other**_____

Do you want:

Phone Consultation? ❑ **Consultation Conference?** ❑ **Psychiatric Evaluation?** ❑

What question/s would you like the COE to address? _____

_____

_____

_____

List psychiatric hospitalizations & dates, mental health history and past therapists, CAC, (Attach List, if necessary): _____

_____

_____

_____

Current medications: _____

Name of current Therapist: _____ **Address** _____
Phone: _____ **Fax:** _____

Name of current treating Psychiatrist: _____ **Address:** _____
Phone: _____ **Fax**: _____

Name of Current Treating PCP: _____ **Address:** _____
Phone: _____ **Fax:** _____

List impairments (vision, hearing, mobility or disabilities): _____

_____

Has this referral been discussed with the family: ❑ Yes ❑ No Last date of contact with family: _____

EDUCATIONAL INFORMATION

Name of School: _____ County: _____ Current Grade: _____

Special Education: ❑ Yes ❑ No Certification: _____

Psycho-educational: ❑ Yes ❑ No

FSW: _____ Signature: _____ Date: _____
Print Name

E-mail Address _____ Phone #(_____) _____

Fax #(_____) _____ Cell #: (_____) _____

Team Leader: _____ Phone# _____ E-mail Address _____

The following information will be needed for all COE Referrals:

*****Social History or Non-Custodial Assessment *****Permanency Plan/Current Notice of Staffing/IPP *All previous psychological/all psychiatric intakes & progress notes/intake summaries *****Last 3 progress notes from current therapist & treating psychiatrist *Hospitalizations: Intake Summaries & Discharge Summaries *Specialized Evaluations: Psychosexual/Neurological Screenings & Reports *All previous medical assessments: EPSD&T and all medical records *Insurance card; Release of Information *Placement History with dates (include all foster home placements) *School Records/Academic Testing & IQ Testing/Behavior Records

NOTE: COE employees are not employees of the Department of Children's Services.