Office: 850-561-8060

Camelot Community Care, Inc.

Referral Form

Date of Referral_____ ☐Emergency Referral Referral Agency: _____

**Referral Source: Name _____ Title _____

Phone _____ Fax_____ Email _____

Client's Legal Name_____

Client's Parent/Legal Guardian _____**Who does the Client live with?**_____

Home Phone: _____ Cell Phone: _____

Physical Address _____ Apt # _____

City_____ State _____ Zip _____ County_____

Mailing Address ☐Same as above

Street: _____ Apt # _____

City_____ State _____ Zip _____ County_____

Date of Birth_____ **Gender:** ☐Male ☐Female

Race: ☐Alaskan Native ☐Asian ☐Black/African American ☐Native American Indian

☐Native Hawaiian or other Pacific Islander ☐White ☐Unknown

Ethnicity: ☐Cuban ☐Hispanic ☐Mexican ☐Other Specific Hispanic ☐Puerto Rican ☐Unknown

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Primary Language: ☐English ☐Creole ☐Spanish ☐French ☐German ☐Mandarin ☐Portuguese

Second Language: ☐English ☐Creole ☐Spanish ☐French ☐German ☐Mandarin ☐Portuguese

Needs an Interpreter? ☐Yes ☐No

Military Status: ☐None ☐Active Duty ☐Discharged ☐Disabled Veteran

Social Security Number: _____ If none, explain: _____

Employment Status:

☐Student ☐Engaged in Residential/Hospitalization ☐Full Time Employed ☐Part-time Employed
☐Homemaker ☐Inmate of Jail/Prison/Corrections ☐Retired ☐Sheltered Employment ☐Disabled
☐Volunteer ☐Unemployed but actively looking for work ☐Other/Not in Labor Force ☐Unknown

Occupation: _____ Job Title: _____ Days worked in the past 30 days: _____

Education Level:

Highest Level Completed: ☐Elementary ☐Middle/Junior High ☐High School ☐Not School Age

Comments: Name of School: _____

Education Type: ☐SED ☐EH ☐Varying Exceptionalities ☐Regular Education

☐Vocational/Job Training, If yes, for how long? ☐In 6 Months ☐In 30 days ☐Unknown

Current Medications: _____

Allergies: _____

***Behavioral Concerns per Client, Family or Referral Source** (Mark "**H**" if issue(s) are historical (over 6 months) and "**C**" if issue(s) are current); **Indicate ALL that apply**:

Abuse
__Victim of **Type:**
__Physical
__Emotional
__Sexual
__Excessive Corporal Punishment
__Neglect

__Perpetrator of **Type:**
__Physical
__Sexual

Anxiety
__Excessive Worry
__Restlessness
__Autonomic Hyperactivity
__Hypervigilance
__Specific Fear_____
__Sleep Disturbance

__**Phobia**_____
__**Obsessive/Compulsive**
_____

Self Harmful
__Cutting
__Burning
_____

Psychotic
__ Hallucinations: __A __V
__ Paranoid thinking
__ Delusions

Attention Deficit/Hyperactivity
__Short Attention Span
__Inattentive
__Impulsive
__Easily Distracted
__Failure to Follow through
__Excessive Talking
__Restlessness
__Difficulty Waiting
__Negative Attention Seeking Behaviors
__Risk Taker
__Projecting Blame
__Low Self Esteem
__Poor Social Skills

__**Low Frustration Tolerance**
__**Enuresis**
__**Encopresis**
__**Hx of Failure to Thrive**
__**Fire Setting**
__**Fire Play**
__**Gang Association**
__**Manipulative/Lying**
__**Learning Disability**

Post Traumatic Stress
__Decreased concentration
__"Flashbacks"
__Avoidance of Issue
__Vigilance
__Sleep Disturbances
__Recurrent nightmares

Eating Disorder
__Self-Induced Vomiting
__Use of Laxatives
__Refusal to Maintain Healthy Weight
__Preoccupation w/Body Image
__Irrational Fear of Becoming Overweight

Sexually Inappropriate Behavior
__Touching
__Exposing

Poor Verbal Skills
__Expressive
__Receptive

__**Pregnancy**
__**Physical/Medical issues**
_____

Depression
__Sad/Flat Affect
__Irritability
__Isolative/Withdrawn
__Reduced Appetite
__Sleep Disturbances
__Unresolved Grief
__Feeling Hopeless
__Hygiene Problems
__Inactive/low motivation
__Excessive Crying

__**Runaway #**_____

__**Mood Disruption**

Oppositional Defiant
__Hostile Towards Adults
__Temper Tantrums
__Constant Arguing w/Adults
__Refusing to Comply
__Blaming Others
__Demanding
__Verbal Aggression/ swearing

Conduct Disorder
__Failure to Comply
__Fighting/Assaultive
__Homicidal
__Intimidation
__Harmful to Animals
__Stealing
__School Maladjustment
__Conflict with Authority
__Risk Taking
__Blaming Others
__Little/No Remorse
__Destruction of Property

Substance Abuse
__Drugs_____
__Alcohol_____

__**Suicidal Attempt #**_____
__**Suicidal Ideation #**_____
__**Suicidal Gestures#**_____

***Family Circumstances:**
__Substance Use/Abuse
__Child Custody Issues
__Incarceration
__Domestic Violence
__Low Intellect of Caretaker
__Lack of parental control and/or supervision

☐ **None Identified**
__Financial Issues
__Marital Issues
__Resistant to Treatment
__Single Parent
__Non-English Speaking
__Lack of knowledge of child development and behavior

__Termination of Parental Rights
__Transportation Issues
__Unemployment
__Threatening Hostile Behaviors
__Family history of abuse
__Family history of neglect

__Unwanted Pregnancy
__Ineffective Parenting Skills
__Significant Medical Problems
__Poor communication and/or interactions
__Other _____

Handicaps/Disabilities at Time of Referral: ☐**None at Referral**

☐Autistic
☐Physically Impaired
☐Emotionally Disturbed
☐MR/Developmentally Delayed
☐Other_____

☐Hearing Impaired
☐Deaf
☐Learning Disability
☐Visual Impairment

☐Blind
☐Language Impaired
☐Traumatic Brain Injury
☐Health Impaired

☐Speech Impaired
☐Functional Delay
☐Multi-Handicapped

Household Information: (FFT Program ONLY)

Annual Household Income: $_____Individuals in your Household: _____ Individuals under 18 in your household: _____

Principal Income Source: ☐ Employment ☐ Family/Relative ☐Alimony ☐Child Support ☐ Savings/Investment

Camelot Community Care, Inc.

Referral Form

Staff to complete:

Profit Center_____ Call Date: _____ Client ID Number: _____

Program 1: ☐**Outpatient** ☐**In-Home** ☐**In-Home 2 (Lauderdale Only)** ☐**TFC Level:** _____
☐**Foster Care** ☐**STFC Level**_____ ☐ **Comprehensive Assessment**
☐ **Independent Living** ☐**TIES** ☐**Respite**

Payer Name 1: _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No Ins Number: _____
Authorization Number: _____ Bill to Staff: _____

Payer Name 2 (if applicable): _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No Ins Number: _____
Authorization Number: _____ Bill to Staff: _____

Program 2: ☐**TIES (Lauderdale Only)** ☐**TCM (Clearwater Only)**

Payer Name1: _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No
Authorization Number: _____ Bill to Staff: _____

Records Requested: ☐**NONE**

☐ Physical ☐ Dental ☐ Immunizations ☐ Case Plan ☐Permanency Plan ☐Shelter Order ☐Funding Letter
☐CBHA ☐Birth Certificate ☐Custody Order ☐ Ins Card ☐ Driver's License ☐ SS Card ☐ Final Adoption Decree

Requested From: _____via ☐ Fax ☐Phone ☐Letter ☐Email ☐In Person

Does the client meet the screening criteria to proceed to Assessment? ☐**Yes** ☐**No** **Date**_____

Date Referral Source Notified _____

If Referral is appropriate--Proceed with Intake Assessment and Complete Below:

Date Assessment Scheduled_____ Time Assessment Scheduled_____

Assessment Scheduled With_____

☐Referral Withdrawn by Guardian and/or Referral source

☐Referral Not Appropriate Due to Exclusionary Criteria: ☐Age ☐Chronic Substance Abuse ☐Chronically Assaultive
☐Needs Higher Level of Care ☐Needs Less Intensive Care ☐Mentally Retarded ☐Actively Psychotic
☐Doesn't Meet Pre-authorization Criteria

Client Referred To_____