Beacon Health Options Referral Form for Youth Home Residential Programs

Please complete form in FULL and fax to 501-821-5582

Client's Name:	□ **M** □ **F**	**Date Completed:**	
Medicaid #:		**Medicaid Tier Determination:**	□ **1** □ **2** □ **3**
Age:		**DOB:**	
Provider's Name & Number:		**Clinic Name & Location:**	

DIAGNOSES:
IQ/Functioning Level:

Client's Current Location: □ Home □ Group Home/Foster Home/Shelter □ Detention □ Hospital □ Other:		
Current Risk Factors:		
□ Suicidal Ideation (Past/Present)	□ Auditory/Visual Hallucinations	□ Somatic Complaints
□ Past Suicide Attempts	□ Trauma/Abuse (Past/Present)	□ Attention Difficulties
□ Self Cutting/Mutilation	□ Legal Issues	□ Social Anxiety
□ Over Sleeping	□ Obsessive Thoughts/Behaviors	□ Grief Issues
□ Lack of Sleep	□ Defiance	□ Involvement w/ Negative Peer Group
□ Weight Loss	□ Elevated Mood	□ Education Issues (Grades/Truancy)
□ Weight Gain	□ Witnessed Violence	□ Physcial/Verbal Aggression
□ Eating Problems	□ Loss of Interest in Activities	□ Homicidal Ideation
□ Family Hx of Suicide Attempts	□ Attachment Issues	□ Poor ADL's (Hygiene Issues)
□ Hopeless Feelings	□ Multiple Placements - Foster Homes, Etc.	
□ Isolating Behaviors	□ Hx of Family Mental Illness/Substance Abuse	
□ Mood Swings (Anger/Sadness)	□ Sexual Activity/Acting Out	
□ Anxiety/Panic Attacks	□ Exposure to Pornography/Inappropriate Sexual Acts	
□ Low Self Esteem	□ Impulsive/Unpredictable Mood and/or Behaviors	
□ Lack of Support System Per Client	□ Drug Use as Coping Mechanism	
□ Lack of Family Support	□ Other Risk Factors:	
□ Instability at Home		

YOUTH HOME

PLEASE EXPLAIN CURRENT DYNAMICS, WORK IN TREATMENT, HOW SYMPTOMS/BEHAVIORS RELATE TO DIAGNOSES, AND WHY RESIDENTIAL TREATMENT IS REQUESTED:
PROGRESS/STRENGTHS:

YOUTH HOME

OUTPATIENT TREATMENT HISTORY:	
Total # of Individual Sessions by LMHP within last 90 days:	
Date of most recent Individual Session attended:	
Have Individual Sessions been increased to address current issues?	□ Yes □ No
Total # of Family Sessions by LMHP within last 90 days:	
Date of most recent Family Session attended:	
Date of most recent Medication Management session:	
Total # of Crisis Interventions within last 90 days:	
Comments:	

PLEASE LIST ALL AGENCIES THAT HAVE BEEN INVOLVED WITH CLIENT'S CARE:			
Contact Name:		Phone:	
	Email:		Dates:
Contact Name:		Phone:	
	Email:		Dates:
Contact Name:		Phone:	
	Email:		Dates:
Contact Name:		Phone:	
	Email:		Dates:
Contact Name:		Phone:	
	Email:		Dates:
Contact Name:		Phone:	
	Email:		Dates:

CURRENT MEDICATIONS:		
Medication Name	Dosage	Frequency Taken/Date Started
Does client take medications as prescribed?	□ Yes □ No	

ALLERGIES: □ None □ Drug □ Food □ Seasonal □ Other (if yes to any, please list all known allergies)

ANY OTHER MEDICAL CONCERNS:

BARRIERS PREVENTING CLIENT FROM ATTENDING SESSIONS:		
□ Financial Difficulties	□ Detention	□ Family Instability
□ Transportation Issues	□ Client Refusal	□ Hospitalization During OP Treatment
□ Mood Instability (Potential Harm to Self and Others During Transport)		
□ Recent Moves/DHS Custody/Multiple Placements		
□ Other:		

INPATIENT TREATMENT HISTORY:		
Date	Location	Reason for Admission

HISTORY OF SUICIDE ATTEMPTS:	
Date:	Method of Attempt:

YOUTH HOME

TRAUMA/ABUSE HISTORY (if yes, please note the date and specifics of incident, including those involved)
Sexual Abuse: □ Yes □ No
Physical Abuse: □ Yes □ No
Neglect: □ Yes □ No
Other Trauma (e.g., accidents, storms, fires, etc.):
Has the above trauma been reported? □ Yes □ No

LEGAL INVOLVEMENT:	
Probation Officer □ Yes □ No	
Name of Probation Officer:	
Phone Number:	County:
Reason for Legal Involvement:	
FINS Officer □ Yes □ No	
Name of Probation Officer:	
Phone Number:	County:
Reason for Legal Involvement:	

EDUCATION:	
Name of School:	Grade:
If Currently Not Attending School, Please Explain:	

FAMILY/GUARDIAN CONTACT INFORMATION:			
Name:		Phone:	
Relationship to Client:			
Address:	City:	State:	Zip Code:

Therapist Signature: _____ Date: _____