Referral for Respite Care Services

Youth's Name: _____

Youth's Date of Birth: _____

Youth's Medicaid Number: _____

Dates/Times Needed: _____

Level of Care: _____

Case Manager's Name and Contact Information:
_____

Provider Preferences: _____

Name of Youth's Parent/Guardian/Custody Agent:
_____

Address of Parent/Guardian/Custody Agent:
_____

Telephone Number(s) of Parent/Guardian/Custody Agent:
_____

YOUTH'S DIAGNOSIS

DSM-V Diagnosis Code:

___ ___ ___.___ ___ _____

___ ___ ___.___ ___ _____

___ ___ ___.___ ___ _____

___ ___ ___.___ ___ _____

___ ___ ___.___ ___ _____

___ ___ ___.___ ___ _____

Youth's Hobbies/Sports/Interests/Likes:

_____

_____

YOUTH'S MEDICAL INFORMATION

Does this youth have allergies? If yes, specifiy:
_____

Describe any ongoing medical needs/concerns (ie. Asthma, seizures, diabetes, acne, etc.):
_____

Is the youth prescribed any NON-psychotropic medications? If yes, specify:
_____

Does the youth struggle with enuresis (bedwetting) and/or encopresis (soiling)? If yes, specify and include frequency
(if child uses Pull-Ups please specify and provide):
_____

Does the youth require assistance with hygiene routines or have any particular routines we should be aware of?
If yes, describe:
_____

YOUTH BEHAVIORS

Behavior	Yes	No
Fire Setting		
Sexual Perpetration		
Sexual Victimization		
Sexualized Behavior		
Verbal Aggression		
Suicidal Ideation		
Suicidal Gestures		
Suicide Attempts		
Other Self-Harm		
Homicidal Threats		
Homicidal Gestures		
Substance Use (include Nicotine)		
Criminal Activities		
Legal Adjudication		
Property Destruction		
Compulsive Behavior		
Eating Disorder		
Sleep Disturbance		
Hyperactivity/Impulsivity		
Rule Challenging		
Running-Away		