Wraparound Oregon - Referral Form

Intake Coordinator: (503) 267-6208 FAX 1 (866) 472-1306

☐ Early Childhood ~ Birth to 8 years old ☐ School Age ~ 8 to 18 years old

REFERRAL DATE: ____

Child/Youth's Name: ____
Birth date: ____
Gender: ____

CORE CRITERIA

- ☐ Child/Youth & family lives in Multnomah county
- ☐ Priority for EI/ECSE eligibility (Early Childhood Only)
- ☐ Priority for risk of placement or already placed
- ☐ Diagnosed or diagnosable mental health conditions
- ☐ Served by multiple agencies/systems
- ☐ Voluntary
- ☐ Youth CASII Score
- ☐ Court Involved

Referral Information:

Person Completing Form: ____
Agency(if applicable) ____
Phone: ____ Extension: ____ FAX: ____ Email: ____

Reason for Referral: Please Provide Explanation

- ☐ Risk of disruption from Home, Preschool or School **(circle one)**: ____
- ☐ Risk of poor transition in school: ____
- ☐ Strengthen and expedite a return home plan: ____
- ☐ Care Coordination needed: ____
- ☐ Dissatisfaction with prior services: ____

Child/Youth's Behaviors of Concern at home & at school: ____

Bonding/attachment Concerns: ____

Mental Health Diagnosis:

Is there a Mental Health Diagnosis for the Child/Youth? ☐ Yes ☐ No
If **NO**, Is one scheduled? ☐ Yes ☐ No When: ____
If **YES**, Date of Diagnosis: ____ Diagnosis provided by Whom: ____

DSM IV:
AXIS I ____
AXIS II ____
AXIS III ____
AXIS IV ____
AXIS V ____
All 5 AXIS **MUST** be completed

Child/Youth Insurance Information: **CASII Score** ☐

OHP ☐ Private: ☐
OHP+ ☐ None ☐

Preschool/School Information ~ Child/Youth participates in:

Preschool/School : ____
Grade: ____
School District: ____

☐ Headstart ☐ Child/Youth care
☐ Private preschool ☐ Play group
☐ Day care ☐ Other ____

Education Evaluation:

Has the Child/Youth been evaluated for Early Intervention/Special Education? ☐ Yes ☐ No
Is the Child/Youth eligible? ☐ Yes ☐ No Date: ____

If **YES**: Does the Youth have a Current IEP? ☐ Yes ☐ No Date of IEP: ____
Does the Child have a Current IFSP? ☐ Yes ☐ No Date of IFSP: ____
Does the Child/Youth have a Section 504? ☐ Yes ☐ No Date of Section 504: ____

FAMILY INFORMATION

Legal Guardian?
Branch Location & Case Worker ______
Address: ______
Main Contact Phone: ______
Alternate Phone: ______

Child/Youth resides with:
Name: ______
Relationship: ______
Phone/Cell:
Address: ______
City : ______ State: ______ Zip: ______

Wants to participate in Wrap Yes [ ] No [ ]

Siblings Names:	Age:	Lives with:

Mother's Info (if resides away from Child/Youth)
Name: ______
Phone/Cell:
Address: ______
City : ______ State: ______ Zip: ______

Wants to participate in Wrap Yes [ ] No [ ]

Father's Info (if resides away from Child/Youth)
Name: ______
Home Phone: ______
Cell or Alternate Phone: ______
Address: ______
City : ______ State: ______ Zip: ______

Wants to participate in Wrap Yes [ ] No [ ]

Cultural Information:
Child/Youth's Primary Language ______ **Interpreter Needed:** Yes [ ] No [ ]
Family's Primary Language ______
Child/Youth's Race/Ethnicity(s): ______
Family's Race/Ethnicity(s): ______
Strengths of Child/Family: *(Values, Traditions, Religious/Spiritual, Other)*

______

Specific Cultural/Linguistic Needs: *(Cultural Connections & Resources, Gender Specific, Hearing/Vision, Other)*

______

Family Stressors:	Current:	History of:	Describe:
Drug and/or alcohol abuse	[ ]	[ ]	
Violence ~ Domestic/Community	[ ]	[ ]	
Homelessness/Lack of stable housing	[ ]	[ ]	
Parental mental health	[ ]	[ ]	
Medical	[ ]	[ ]	
Criminal justice	[ ]	[ ]	
Lack of stable income	[ ]	[ ]	

List all Agencies involved with the family: ______

______

Authorization/Signatures:

______
LEGAL GUARDIAN **DATE:**
I consent to have my Child/Youth/family considered for the Wraparound program, and to be contacted for additional information.

______
LEGAL GUARDIAN **DATE:**
I consent to have my Child/Youth/family considered for the Wraparound program, and to be contacted for additional information.

______
REFERRAL SOURCE **DATE:**
I attest that this child/youth/family meets the criteria and have shared all referral information with the legal guardian.

Intake/Referral Form & Release Form MUST be completed

DISPOSITION: ~ To be filled out by Intake Coordinator

INTAKE DATE: ____________________

Accepted ☐
Pended ☐
Declined ☐
Denied ☐
Reason: ____
____

First date of Contact: ____________________

Opened ☐ Date: ____________________

Enrolled ☐ Date: ____________________

Committee's Recommended Steps:

____
____
____
____
____
____
____
____
____
____

Intake/Referral Form & Release Form MUST be completed