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
☐ 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: ______
☐ Fragmented care coordination: ______
☐ Dissatisfaction with prior services: ______

Child/Youth's Behaviors of Concerns 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:
OHP ☐ Private: ☐
OHP+ ☐ None ☐

CASII Score ☐

Preschool/School Information ~ Child/Youth participates in:

Preschool/School : ______
Grade: ______
School District: ______

☐ Headstart
☐ Private preschool
☐ Day care
☐ Child/Youth care
☐ Play group
☐ 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?
Agency & Case Worker:
Location:
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	☐	☐	

Family & Community Supports:

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:

____
____
____
____
____
____
____
____
____
____

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