REFERRAL FORM

Campbell PSYCHOLOGICAL SERVICES

CHECK ONE:

☐ Referral has been discussed with youth/family. Family agrees with referral and caregiver is expecting a call from Campbell Psychological to schedule.

☐ Caregiver will contact Campbell Psychological to schedule.

REFERRAL IS FOR: (select only one to start)

☐ Outpatient Therapy

☐ Trauma-Focused Mental Health Assessment

☐ Psychological Evaluation

YOUTH

Name: _____ DOB: _____

Address:_____

Gender: _____ Age: _____ Grade: _____ School: _____

Primary Language:_____

Can the youth speak and understand English fluently?

☐ Yes
☐ No
☐ I'm not sure

CAREGIVER

Name: _____ Relationship: _____

Address: _____

Phone: _____ (cell / home / work)

Primary Language: _____

Can the caregiver speak and understand English fluently?

☐ Yes
☐ No
☐ I'm not sure

REFERRAL SOURCE

☐ Cumberland County Juvenile Probation Office

☐ Cumberland County Children & Youth Services

Contact Person: _____ Title: _____

Phone Number: _____ Email: _____

Return via fax to (717) 620-0536 or mail to 25 East North Street, Carlisle, PA 17013
Please call (717) 422-6440, if you have questions

<u>CHECKLIST</u> (mark box if attached – please attach as much information as possible)

For all referrals:

- ☐ Copy of youth's insurance card
- ☐ Release of Information for Juvenile Probation – ***For youth <14 years old, the release must be signed by a legal guardian. For youth 14+, the youth must sign.***
- ☐ Results of YLS (if available)

Referrals for Assessment or Evaluation:

- ☐ Campbell Psychological Services Intake Questionnaire for Youth – ***to be completed by caregiver or another adult who is familiar with youth's early childhood and background***
- ☐ Other: _____

<u>REASON FOR REFERRAL</u> (feel free to attach additional pages/information)

If youth has an identified trauma history, please provide any information you have about the trauma experienced by this youth:

Please provide any additional information you have regarding emotional or behavioral concerns.

<u>OTHER SERVICES</u>

Please list all services/programs that are currently in place or to which the youth has already been referred and any other county agencies that are involved.

_____ ☐ Referred ☐ Currently receiving

_____ ☐ Referred ☐ Currently receiving

_____ ☐ Referred ☐ Currently receiving

_____ ☐ Referred ☐ Currently receiving

_____ ☐ Referred ☐ Currently receiving

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ with the Date of Birth _____/_____/_____
Client's Name Month Day Year

authorize **Campbell Psychological Services** to exchange information from my record(s), verbally or in writing, as described in Sections I and II below, with the following individual or entity:

Person or Entity: Cumberland County Juvenile Probation Department (JPO) Phone: (717) 240-6265

Address: 16 West High Street, Suite 100, Carlisle, PA 17013 Fax: (717) 240-7880

I: Campbell Psychological Services may release the following information to the party listed above:

- ☐ Attendance in treatment
- ☐ Intake Summary
- ☐ Treatment Plan/Recommendations
- ☐ Progress Notes
- X Evaluation / Assessment / Testing results or reports
- ☐ Treatment Summary / Progress in treatment
- ☐ Discharge Summary
- X Other: status of scheduling and attendance; recommendations for treatment/ services; consultation to JPO; past involvement with Campbell Psych

II: Campbell Psychological Services may receive the following information from the party listed above:

- ☐ Attendance in treatment
- ☐ Intake Summary
- ☐ Treatment Plan/Recommendations
- ☐ Treatment Summary / Progress
- ☐ Progress Notes
- ☐ Assessment / Evaluation Results
- ☐ Discharge Summary / Aftercare Plans
- ☐ Social History
- ☐ Medical Record
- ☐ Medication Management Notes
- ☐ Academic Records
- ☐ Teacher Observations / Feedback
- ☐ Completed Rating Scales
- ☐ Court Records
- ☐ Other: _____

Information is to be used for the purposes of:

- ☐ Treatment planning
- ☐ Coordination of care
- X Assessment or Evaluation
- X Other: Provide information to JPO to guide service planning, taking into consideration the client's mental health and any posttraumatic symptoms

This authorization will expire:

- ☐ Six (6) months after discharge from Campbell Psychological Services
- X Other: Twelve (12) months from date of signature

I understand that I have the right to cancel this authorization at any time, by providing such request in writing to *Campbell Psychological Services* at 25 East North Street, Carlisle, PA 17013. However, my revocation will not be effective to the extent to which actions have been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not require that I sign an authorization in order to receive services, unless the services are being provided to me for the purpose of creating health information for a third party.

I further understand that the potential exists for re-disclosure of my private mental health information by the recipient of that information. Once disclosed, the information may no longer be protected under the HIPAA privacy regulations.

_____ _____
Signature of client, if 14 years or older Date

_____ _____ _____
Signature of parent or guardian (for clients under age 14) Date Relationship to client

_____ _____ _____
Signature of second parent or guardian Date Relationship to client

Client ____accepted / ____ declined a copy of this release