Gateway-Longview Children & Family Treatment & Support Services Referral (CFTSS)

How to make a Referral:

Complete this referral form and send to:

CFTSSReferrals@gateway-longview.org

6350 Main Street, Williamsville, NY 14221

Behavioral Health Services Intake: (p) 716-783-3100 ext. 3108 (f) 716-633-7922

**Referral Source Information**

|  |  |
| --- | --- |
| Referral Source Name: | Date of Referral: |
| Organization: | Department: |
| Email: | Phone: |

**Client Information**

**Child’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_ **SSN**#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race**: White Black/African American Asian American Indian Native Hawaiian/Pacific Islander Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Religion**: Catholic Muslim Jewish Christian Buddhist Hindu Unaffiliated Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth Gender**: M F **Gender Identity**: Cisgender Agender Bigender Intersex Mx Gender Variant Trans Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity**: European Hispanic African Arab Chinese Caribbean Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Interpreter required**? \_\_\_Y \_\_\_N

**Language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Current Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_

**Guardian Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Legal Custody Status:**  **\_\_**Both parents together **\_\_**Joint Custody  \_\_ Biological mother only \_\_ DSS Case worker name and #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_Biological father only \_\_Adult Sibling  \_\_Adoptive Parent \_\_Other Legal Guardian (Describe) |
| **Current providers:**  School/District and Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Therapist/Therapist Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Psychiatrists/Psychiatrist Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Is the client currently enrolled in any of the following services**: |
| \_\_\_\_ Currently in a Residential Setting |
| \_\_\_\_ Currently enrolled and receiving OPWDD Services |
| \_\_\_\_ Care Coordination / WRAP **Provider:** |
| \_\_\_\_ Health Homes **Provider:** |
| Other: |

*Risk Factors - Check All that Apply*

\_\_\_Suicide Ideation/ History Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Homicidal Ideation / History \_\_\_Drug use/History

\_\_\_Repeat ED or Inpatient visits \_\_\_ Self-Injurious Behaviors

\_\_\_Violent behaviors

\_\_\_Has recently been released from incarceration, placement, detention, or psychiatric hospitalization

**Insurance Information**

Insurance company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County of Residence: \_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID / CIN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid ID / CIN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children & Family Treatment & Support Services**

|  |  |
| --- | --- |
| \_\_Other Licensed Professional (OLP)  \_\_\_Assessment, Establish a Diagnosis  \_\_\_Individual Therapy  \_\_\_Family Therapy  \_\_ Complex Trauma Assessment for Health Homes | \_\_\_Community Psychiatric Support and Treatment (CPST)  **\*\*Please choose one\*\***  **\_\_\_\_**Supportive Counseling \_\_\_ Psychoeducation |
|  |  |

|  |  |  |
| --- | --- | --- |
| **LIST** | **Mental Health Diagnosis** | **DX Code** |
| Primary |  |  |
| Secondary |  |  |
| Other |  |  |

**Areas of Functioning:** As a result of the symptoms or diagnosis, the child/youth has functional impairment that interferes with or limits functioning in at least one of the areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms.

|  |  |  |
| --- | --- | --- |
| **CHECK** | **Domain** | **Description of Impairment** |
|  | **Self-Direction** |  |
|  | **Self-Care** |  |
|  | **Family life** |  |
|  | **Social Relationships** |  |
|  | **Symptom Management** |  |
|  | **Behavior Modification** |  |
|  | **Other:** |  |

Please describe why you are requesting these services and any additional information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are there any safety concerns for the worker, providing services within the Child’s home environment?**

\_\_\_\_ No

\_\_\_\_ YES: Please describe: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***CPST services only:***

**\*\* By signing below, I am recommending the above-named individual for Child and Family Treatment and Support Service(s)**

This form can only be signed by a Licensed practitioner of the Healing Arts; Registered Professional Nurse, NP, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, LCSW, LMFT, LMHC, LCAT, or Physician.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LPHA Signature and License Type Printed Name NPI # Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LPHA Signature’s provider agency name and address