CRISIS REFERRAL FORM -

CHILD/YOUTH CRISIS RESIDENCE SUPPORT PROGRAM
17 Wells Street Plattsburgh, NY 12901
Phone: 518 557 4500 Fax: 518-563-3704 Email: crisisreferrals@bhsn.org

Basic Client Information	**Referral Date:**
Legal Name:	
Parent/Guardian Name:	
(Physical) Address:	
County of Residence:	Preferred Name:
Phone #:	Preferred Pronouns:
Primary Language:	SSN#:
Child/Youth School:	DOB:
Pediatrician/Primary Care Doctor:	Ethnicity:

Financial Information			
Insurance Policy:		Policy ID:	
Policy Holder Name:		Medicaid #:	
Policy Holder DOB:		Medicare #:	

Referral Information (Please ensure to give direct contact lines, for streamlined communication)	
Individual Making Referral Name:	
Representing which Agency/Hospital:	
Address:	
Phone:	
Fax:	
Email:	

Mental Health History	
Current Mental Health Treatment? (Where)	
Current Family Sessions? (Where/compliance)	

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Mental Health Diagnosis?	
Treatment Compliance/ Engagement?	
Current Medications?	
Medical conditions/ Physical limitations: To include diabetes, Use of walker, etc.	
Inpatient Hospitalizations (Where, Dates of last 90 days, why?)	
Probation (Dates, Charges, probation contact information)	
Health Home Care Management? Community residence/supported housing?	

Known Risk Factors:	**Present** within 14 days	**Past** More than 14 days ago	**No known History**	Comments- must include most recent date, details, and impact

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Suicidal (Ideation, attempts) *Include most recent Columbia*				
Elopement				
Violence				
Physical Harm to others				
Destruction of Property				
Domestic Violence / Restraining Orders				
Fire Setting				
Sexually abusive				
Incarceration				
Outbursts				

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Command Hallucinations				
Drug/alcohol abuse				
Frequent Crisis Contacts				
PINS Program				
Poor School Attendance/ Suspensions/ Disciplinary				
Non-Suicidal Self Injurious Behavior				

Independent ADLs to include:	**Yes**	**No**	**Limited with Support**	**Identify Support needs to accomplish ADL**
Toileting				
Feeding				
Bathing				
Evacuating in Emergency				
Dressing				
Taking Medication				
Medical Needs				

Reason for CRISIS Residential Need

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Current Acute Psychological/emotional change:
Client's current resources/supports:
Current symptoms of distress:
How are current impairments in Mood/thought/behavior impacting client's home, school or community?
What treatment services have been attempted to aid in managing the above distress so far and what was the client and family's response?
What self-identified MENTAL HEALTH GOALS does the client feel prepared and willing to focus on during their admission to the crisis residence?

Are Parent/Family/Guardian aware of Referral?	
Are Parents/Family/Guardian in agreement with referral?	
Is Child aware of referral?	
Is Child in agreement with referral?	
Have Parent/Family/Guardian and Child been made aware that a referral does not guarantee placement?	

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Are Parent/Family/Guardian willing to actively engage in services to include family therapy sessions?	
Discharge Location:	

** ALL Referrals will be reviewed by the Program Clinical Team to include Program Director and Program Coordinator **

Signature of Referral Source: _____ Date: _____

Reviewed By: _____ _____ Date: _____

Referrals should be sent to crisisreferrals@bhsn.org and they will be reviewed by the Program Clinical Team to include Program Director and/or Program Coordinator within 24 hours. If the need is urgent, please send a referral via email and then contact Mobile Crisis via 1-866-577-3836. The Mobile team will review with Program Director and/or Program Coordinator upon receipt. *Additional documents can be faxed as needed to 518-563-3704.*