VALLEY MENTAL HEALTH CHILDREN'S SERVICES REFERRAL

CHILDREN'S OUTPATIENT SERVICES
1141 E. 3900 S. #A-170
SLC, UTAH 84121
(801) 284-4990
FAX (801) 284-4991
Karen Platis, LCSW Program Manager (contact person)
e-mail: karenp@vmh.com

1. Referring Partner Information		Referral Date			
Referring Agency		Fax Number			
Staff Member's Name		Work Phone			
2. Child / Youth & Family Information		G Male G Female			
Child / Youth Name		Birth Date		Age	
Caregiver(s) Name		Relationship			
Street Address		Home Phone			
City, State, Zip		Work Phone			

Has the parent or caregiver given the Mental Health Center permission to contact him/her at work? Yes G No G
Is the child / youth or family court-ordered to participate in services? Yes G No G
Is the child / youth identified as title V? Yes G No G
How will mental health services be funded? G Medicaid G Chip GOther Insurance G Private Pay G Unfunded

3. Focus Of Mental Health Services

Please describe the focus for referral for mental health services.

4. Referred Family's Preferences

Partnering agencies occasionally refer to services that families do not want, do not actually need or cannot afford. To avoid this, the Community Mental Health Center (CMHC) meets with the child / youth and family to complete a Comprehensive Mental Health Assessment before planning services. Service planning is based upon the family's preference, circumstances and the clinical assessment. Please do not refer for specific services.

5. Referring Partner's Preference

How soon should we meet with the family? G Within an hour G Within 5 working days G Within 15 working days

Upon the receipt of this form, or a facsimile, the CMHC will make every effort to involve this child / family in services. However, we will not contact the family without the parent / guardian's signature on this release form. Within the time-frame selected, we will send you a fax regarding our progress of involving this family in services

Will the referring agency be mailing records to supplement the assessment? G Yes G No
Will you like a copy of the *Comprehensive Mental Health Assessment?* G Yes G No
Would you like a copy of the *Treatment Plan?* G Yes G No

6. Release Of Information & Consent for Coordinated Services

I understand that my child's records are protected under State and Federal regulations as well as professional codes of ethics governing confidentiality and cannot be disclosed without my written consent unless otherwise provided for in the State and Federal regulations. I authorize the release of information from the referring agency (listed above) to the CMHC, with the restriction that said information cannot be passed on to any other person or entity.

This information is to be released for the following purposes only: 1) to allow the CMHC to initiate services, 2) to provide records that supplement the mental health assessment(s), 3) to promote the individualization of mental health service planning, and 4) to allow the CMHC and the referring agency listed above to continue to collaborate in my child / family's behalf

Guardian's Signature		Date	