Care Coordination Services Referral

Page 1 and 2 must be completed for referral to be processed.

Please complete a separate referral form for each individual child who requires services

Referral Agent Name:	Agency/School:
Referral Agent Phone #:	Email address

Parent/Guardian Name:	Parent/Guardian Phone #:
Address:	Parent/Guardian email address:

Child's Name:	Date of Birth:
Social Security:	Gender:

Child Address (if different than above)	Preferred language of parent/guardian:

Mother/Caregiver	Father/Caregiver
Name:	Name:
Date of Birth:	Date of Birth:

School:	Grade:	ESE:

Insurance Coverage:	Medicaid Number:

Does child have a current documented mental health diagnosis? ☐ Yes ☐ No

Diagnosis:	Date of Diagnosis:

If yes, describe here: _____

Care Coordination Services Referral

Current Needs that Require Coordination of Services

Check ALL that apply:

- ☐ Mood (Depression/Anxiety)
- ☐ Behavior Issues/Concerns
- ☐ Medical Health Concerns
- ☐ Legal Issues (DJJ, DCF)
- ☐ Substance Use/Abuse
- ☐ Developmental Needs
- ☐ School-Related Concerns
- ☐ Danger to self or others
- ☐ Concrete needs (housing, community resources)
- ☐ Vocational Needs/Independent Living
- ☐ Safety Concerns
- ☐ Other:

Please list any prescribed psychotropic medication and dosage:

Medication	Dosage

Prescribing Doctor:
Known Allergies:
Known Medical Conditions:

List name(s) of other service providers who are currently working with family

Service Provided	Provider Name and Phone Number

List name(s) of other service providers who worked with the family in the past year:

Service Provided	Provider Name and Phone Number

Referral can be faxed to (561) 612-6097, Attn: CCS Admission Services Representative, or emailed to CCSReferralsSFL@Boystown.org. If you have any questions please call (561) 612-6000.

*(Please attach any supporting documentation you may have with this referral)**