Care Haven Referral Form

2533 Airport Rd, Marion NC 28752

House Manager Contact Number: (828) 608-3408/ Fax (828) 559-0773

Email: carehaven@caringalternative.com

FORM MUST BE FILLED OUT FULLY IN ORDER TO BE CONSIDERED FOR RESPITE CARE

Client Demographic Information/Facesheet

Client's Name:

Nickname:

Date of Birth:

Age:

Sex: ☐Male ☐Female ☐Transgender

Race:

Medical Insurance Company: ☐Medicaid ☐ NC Health Choice ☐ Private Insurance: _____

Medicaid Number**:**

Weight:

Height:

Eye Color:

Client's Legal Address:

Client is currently transitioning **from:** ☐Foster Home ☐ Therapeutic Foster Home ☐ Group Home ☐PRTF ☐ Legal Guardian/Parent/Custodian's Home

Client is planning to transition **to:** ☐Foster Home ☐ Therapeutic Foster Home ☐ Group Home ☐PRTF ☐ Legal Guardian/Parent/Custodian's Home

Primary Language:

Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.):

Legal Guardian:

Relationship to Client:

Legal Guardian Contact:

Care Haven Referral Form

Referral Source

Referral Source: ☐ MCO/LME ☐ DSS ☐ MH Provider ☐ DJJ ☐ Parent ☐ Other: _____

Referral Contact Name: _____ Phone: _____ Date: _____

Referral Email: _____

Diagnosis Information- Please list all the client's current mental health diagnosis

Medical Information-

List of Allergies/Poorly Tolerated Meds: ☐None/ _____

EpiPen: ☐Yes ☐No

Special Dietary Needs: ☐None/_____

Please check for any of the following current medical conditions & note when possible.

☐ Anemia	☐ HIV/ AIDS	☐ Tuberculosis	☐ Hay Fever/ Sinus Problems	☐ Hepatitis
☐ Bulimia	☐ Migraines	☐ Anorexia	☐ Seizures/ Convulsions	☐ Measles
☐ Diabetes	☐ Rubella	☐ Stomach Issues	☐ Asthma	☐ STD
☐ GERD/ Acid Reflux	☐ Sickle Cell Anemia	☐ Hay Fever	☐ Chronic Urinary/ Bowel Problems	☐ Traumatic Brain Injury

Explanation for any that are checked:

: Care Haven Referral Form

History (H) and Current (C) Mental Health and Behavioral Concerns:

- **For any symptom that is marked as "current"; please list effective coping skills/interventions to the right of current symptoms**
- **For any symptom that is marked as "historical"; please list the most recent date that the symptom was displayed**

☐H ☐C Abandonment Concerns		☐H ☐C Sexually Inappropriate Behavior	
☐H ☐C Alcohol/ Drug Abuse		☐H ☐C Eating Disorder	
☐H ☐C Physically Aggressive		☐H ☐C Fire Setting	
☐H ☐C Bedwetting		☐H ☐C Hyperactive	
☐H ☐C Property Destruction		☐H ☐C Low Self Esteem	
☐H ☐C Current Danger to Others		☐H ☐C Sibling Related Difficulty	
☐H ☐C Loss/Grief Difficulties		☐H ☐C Running Away	
☐H ☐C Social Immaturity		☐H ☐C Self Harm	
☐H ☐C Suicidal Attempts		☐H ☐C Cruelty to Animals	
☐H ☐C Problems With Sleep		☐H ☐C Gang Related Activity/Criminal Activity	

: Care Haven Referral Form

☐H ☐C Unrealistic expectation of reality		☐H ☐C Depression	
☐H ☐C Defiant/ Struggles to follow simple directions		☐H ☐C Developmental Disability	
☐H ☐C Anxiety		☐H ☐C Impulsive	
☐H ☐C Antisocial Behavior		☐H ☐C Lying	
☐H ☐C Stool/Feces Smearing		☐H ☐C Stealing	
☐H ☐C Verbally Aggressive		☐H ☐C Hygiene/ Cleanliness	

The client's above noted mental health and behavioral concerns has been a concern in which of the following areas?

☐ School (peer and teacher relationships) ☐ Home (direct family members) ☐ Community (struggles with outings)

☐ Therapeutic (struggles engaging in recommended therapy) ☐ Other placements:_____

Trauma History: ☐Neglect ☐Physical Abuse ☐Sexual Abuse ☐Dependency ☐Other _____

Cultural/Lifestyle Recommendations:☐Yes ☐No

_____

Care Haven Referral Form

Treatment History: Please check services that the client has been engaged in within the past 6 months. If a service is current (C) please list the agency involved to the right.

☐H ☐C OPT		☐H ☐C Substance/Alcohol Program	
☐H ☐C Therapeutic Foster Care		☐H ☐C Psychological Evaluation	
☐H ☐C MH/SA Inpatient		☐H ☐C Group Home	
☐H ☐C Medication Management		☐H ☐C PRTF	
☐H ☐C IIHS/MST		☐H ☐C Psycho-Sexual Eval	

Other pertinent information regarding the client's need for respite or summary of client's recent mental health/behavioral concerns:

_____

_____

_____

_____

_____

_____

_____

Referring Signature/ Title_____ _____

Date: _____