Livingston County Trauma Informed Assessment/Consultation Referral Form

Please complete the following information in order to make a referral to the Livingston County Trauma Informed System of Care. Please fax the referral form and following documents to LACASA (Fax number-517-548-3034)

ELIGIBLILITY CRITERIA

Child IS:

- *A Livingston County Resident (Livingston County jurisdiction)*
- *SED-Serious-mental health, behavior or emotional disorder*
- *0-18 years of age*

AND: Has experienced trauma/ abuse or neglect.
AND/OR: Is in or at risk of an out of home placement.
AND/OR: Is or has received services from multiple systems/agencies
AND/OR: Is receiving services but continues to escalate or is not benefiting from those services

After reviewing the eligibility criteria, the Trauma Informed System of Care will determine if the children is eligible for a Trauma Assessment or a Trauma Consultation.

For a Trauma Assessment, the child will meet with a Livingston County Trauma Informed team and complete a series of assessment tools and the Livingston County Trauma Informed team will create a report and recommendations for the child.

For a Trauma consultation, the Livingston County Trauma Informed team will meet with the referral source, family members and other supports and the Livingston County Trauma Informed team will create recommendations.

Please check if the following documents are available and attach them to the referral form

- ☐ Evaluations/treatment plans conducted within the last year
- ☐ Initial Service Plan (ISP)/Updated Service Plan (USP) if applicable from DHHS
- ☐ Court Orders/Reports
- ☐ Current School records/reports
- ☐ Signed releases

Name of individual completing referral form: _____

Agency_____ Date_____
Address_____ Work phone_____

1. Is the child a Livingston County Resident? ☐ Yes ☐ No

2. Does the Child have a current diagnosis? ☐ Yes ☐ No
   If yes, specify _____

   Does the child have behavior issues/concerns in the following areas?
   Home ☐ Yes ☐ No
   If yes, specify _____

School ☐ Yes ☐ No
If yes, specify _____
Community ☐ Yes ☐ No
If yes, specify _____

Substance Abuse Issues ☐ Yes ☐ No
If yes, specify _____

Suicidal Behavior ☐ Yes ☐ No
If yes, specify _____

Does the Child have a current CAFAS Score? ☐ Yes ☐ No If yes, specify score _____

3. Is the Child between the ages of 0 to 18 years old? ☐Yes ☐ No

4. Has the child experienced trauma, abuse or neglect? ☐ Yes ☐ No

Please check all that apply and describe including who abused the child, when, etc.

☐ Physical abuse
_____
_____

☐ Sexual abuse
_____
_____

☐ Emotional/Verbal Abuse
_____
_____

☐ Neglect
_____
_____

☐ Domestic Violence
_____
_____

☐ Substance abuse
_____
_____

☐ Exposure to Crime
_____
_____

☐ Death/Loss
_____
_____

☐Other trauma

_____

_____

Has abuse/neglect been substantiated? No ☐ Yes ☐ Date:_____

5. Is the child at risk of or in out of home placement due to their behavior? ☐Yes ☐No

6. Is the child receiving services or has the child received services from multiple systems or agencies?
☐Yes ☐No

Service Provider	Check if in service	Dates of Service	Is service provider aware of referral? (yes or no)	Is service provider willing to participate in referral? (yes or no)
DHHS				
CMH				
Special Education or 504 eligible				
Wraparound				
Public Health				
Juvenile Court				
LACASA				
Liv. Family Center				
Connection				
Catholic Charities				
Substance Abuse				
Other Counseling				
Other, _____				
Other, _____				

7. Is the child's behavior continuing to escalate or are they not benefiting from the current services?
☐Yes ☐No

Comments

_____

_____

IDENTIFYING DATA:
Name of Child:_____

Sex: ☐Male ☐Female
Date of Birth _____ Age: _____
Race _____ Primary Language Spoken at Home_____

Where is the child currently residing?
☐Home ☐Hospital ☐Residential

☐Crisis Residential ☐Detention ☐Foster Care
☐Relative ☐Other, Specify _____
Current Address_____ City _____ Zip Code _____
With whom does the child reside (relationship): _____

List the names and relationships of individuals who also reside in the home
_____ _____

_____ _____

_____ _____

How long has the child lived at this placement?_____
Home Phone_____
Social Security #_____ Medicaid #/Insurance Info._____

Name of current guardian_____
Relationship to child _____
Address (if different)_____ Home Phone_____
Place of employment _____ Work Phone_____
Cell Phone _____
Name of biological mother (if applicable)_____
Address (if different)_____ Home Phone_____
Place of employment _____ Work Phone_____
Cell Phone _____
Name of biological father (if applicable)_____
Address (if different)_____ Home Phone_____
Place of employment _____ Work Phone_____
Cell Phone _____

What are the current concerns that led to referral? _____
_____
_____
_____
_____

What has been tried so far? (i.e. psychiatric medication, counseling)
_____
_____
_____

Referral Source identified outcomes for assessment:
_____
_____
_____

********** **FOR INTERNAL USE** **********

TISOC Screening Date:_____

Accepted for Assessment? ☐ Yes ☐ No Accepted for Consultation? ☐ Yes ☐ No

Recommendations:_____
_____
_____
_____