

# 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)

<i>ELIGIBILITY CRITERIA</i>
<i>Child IS:</i> <ul style="list-style-type: none"><li>• <i>A Livingston County Resident (Livingston County jurisdiction)</i></li><li>• <i>SED-Serious-mental health, behavior or emotional disorder</i></li><li>• <i>0-18 years of age</i></li></ul>
<i>AND: Has experienced trauma/ abuse or neglect.</i>
<i>AND/OR: Is in or at risk of an out of home placement.</i>
<i>AND/OR: Is or has received services from multiple systems/agencies</i>
<i>AND/OR: Is receiving services but continues to escalate or is not benefiting from those services</i>

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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

TISOC Screening Date: \_\_\_\_\_

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

Recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_