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)

ELIGIBILITY 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

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<tr>
<th>Service Provider</th>
<th>Check if in service</th>
<th>Dates of Service</th>
<th>Is service provider aware of referral? (yes or no)</th>
<th>Is service provider willing to participate in referral? (yes or no)</th>
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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: __________________________________________________________
________________________________________________________________________
________________________________________________________________________