Child's Initials: _____

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 documents to LACASA

Attention: LTAT Program (Fax #: 517-548-3034) or TISOC@lacasacenter.org

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 child 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 (required, along with referral form)

Name of individual completing referral: _____

Agency: _____ Date: _____

Address: _____

Work phone: _____ Email: _____

Name of Child: _____

Gender:☐Male☐Female ☐Other: _____

Child's Initials: _____

Date of Birth: _____ Race: _____Primary Language: _____

Current School: _____ Current Grade Level: _____

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

☐Detention ☐Foster Care ☐Relative ☐Other, Please specify: _____

Child's Current Address: _____ City: _____ Zip Code: _____

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

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? _____

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

Social Security #_____ Medicaid #/Insurance Info._____

Name of current legal guardian/s: _____

Relationship to child: _____

Address (if different): _____

Home Phone: _____ Cell Phone: _____

Email: _____

Name of Mother: _____

☐ Biological ☐Adoptive ☐Step ☐ Other: _____

Address (if different): _____

Home Phone: _____ Cell Phone: _____

Email: _____

Name of Father: _____

☐Biological ☐Adoptive ☐Step ☐ Other: _____

Address (if different): _____

Home Phone: _____ Cell Phone: _____

Email: _____

Child's Initials: _____

1. Has the child even been diagnosed with a psychiatric, substance abuse, learning, emotional or behavioral disorder? ☐Yes ☐No If yes, please specify:

   _____

   _____

2. 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 _____

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

4. Has the child received services from multiple agencies? ☐Yes ☐No If yes, please specify below

Service Provider	**Check if in service**	**Dates of Service of Service**
DHHS		
CMH		
IEP/504		
Wraparound		
Public Health		
Juvenile Court		
LACASA		
Liv. Family Center		
Connection		
Catholic Charities		
Substance Abuse		
Other Counseling:		

5. 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? ☐ Yes ☐ No Please specify Date/s:

_____

_____

Is the child's behavior continuing to escalate or are they not benefiting from the current services?

_____

_____

_____

Child's Initials: _____

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:

_____
_____
_____
_____

Any additional concerns or information:

_____
_____
_____

Suggested Documents:

☐ 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

Required Documents:

☐ Referral Form
☐ Signed releases

Please fax the referral form and documents to LACASA

Attention: LTAT Program (Fax #: 517-548-3034)

Or email referral form and documents to
TISOC@lacasacenter.org

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

TISOC Received Date: _____ TISOC Review Date: _____

Accepted for Assessment? ☐ Yes ☐ No

Accepted for Consultation? ☐ Yes ☐ No

Notes: