



# Wraparound Orange Referral Form

*For completion please type all referrals by clicking the line and then typing. Move from line to line via Tab button.*

**Youth's Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Gender:**  Male  Female

**Parent/Guardian:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Alternate #:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City and Zip code:** \_\_\_\_\_

**Name of Apartment or Subdivision:** \_\_\_\_\_

**Referred by (Name/Title/Agency/Phone Number):** \_\_\_\_\_

**Primary Language Spoken in the Home:** \_\_\_\_\_ **Bilingual Needed:**  YES  NO

**Youth's Race:**  White  Black or African American  America Indian or Alaska Native  Asian  
 Native Hawaiian  Pacific Islander  Other:

**Youth's Ethnicity:**  Puerto Rican  Mexican, Mexican American or Chicano,

Cuban or other Hispanic, Latino or Spanish Origin  Not of Hispanic/Spanish/Latino origin  Other:

**School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**School contact and #:** \_\_\_\_\_

**Education Plan**  Yes  No **Type:** \_\_\_\_\_

**Most Recent Mental Health Diagnosis and date diagnosis given:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Substance Use Diagnosis and date diagnosis given:** \_\_\_\_\_

**Is youth currently in an out of home placement?**  Yes  No

**Where:** \_\_\_\_\_

**Expected Length of stay:** \_\_\_\_\_

**Current Service Providers (please provide Name, Agency and Phone Number):**

**Child Welfare Worker:** \_\_\_\_\_

Diversion  Protective Investigations  Protective Services  Unknown

Juvenile Justice Worker: \_\_\_\_\_

Counselor/Therapist: \_\_\_\_\_

Targeted Case Manager: \_\_\_\_\_

Other(s) : \_\_\_\_\_

Reason for Referral: (describe mental health symptomology that requires intensive wraparound services): \_\_\_\_\_

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

**Prior to referral, the family has been informed of wraparound services and is aware they will be contacted. Attach a release of information to receive notification of result of referral.**

**Referrals – For problems or questions call 407-836-6547.**

Referrals from a SECURE/ENCRYPTED EMAIL system can be sent to [wraparound.orange@aspirehp.org](mailto:wraparound.orange@aspirehp.org)  
\*\*\*secure systems require a registration and log-in as required by your agency Referrals form  
UNSECURED email systems. type \*\*Secure\*\* in the subject line of all emails that contain Protected Health Information (PHI).

Send by fax to: 407-667-1623

**For Wraparound Staff ONLY**

Referral received by \_\_\_\_\_ Date Received \_\_\_\_\_

Date Reviewed \_\_\_\_\_ Assigned to: \_\_\_\_\_

If denied reason: \_\_\_\_\_

Follow-up provided: \_\_\_\_\_

*This referral contains confidential information which is protected health information (PHI) as defined by the federal Health Insurance Portability and Accountability Act (HIPAA) privacy rule. This information is intended for the exclusive use of Wraparound Orange and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient of this information you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify Wraparound Orange by telephone at 407-836-6547 to arrange the return or destruction of information and all copies.*