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: ENGLISH **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 407-836-1589.

Referrals from a SECURE/ENCRYPTED EMAIL system can be sent to 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.