



Bear Paw Kids Management Authority (KMA) Referral Form



Revised 5-30-2007

Name of person completing form: _____ Date: _____

Agency: _____ Phone: _____

Address: _____

Identifying Information:

File # _____

Child's Name: _____ DOB: _____ Age: _____

Gender: _____ Ethnicity: _____ SSN: _____

Child's Address: _____

Mother's Name, Address, Phone #: _____

Father's Name, Address, Phone #: _____

Legal Custody: (if other than Parent): _____

List ALL persons living with the child, relationships and ages: _____

Reason for Referral:

Current and Past Funding Sources

Check the box under C for current funding source and under P for funding in the last 6 months (Check all that apply):

| | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| C | P | C | P | C | P | C | P | C | P |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicaid | C.H.I.P. | Juvenile Parole | CPS/CFSD | Self-pay | SSI | Youth Court | Adoption Subsidy | Tribal Affiliation | Insurance |

Problem Checklist Check the box under C if it is a current problem and under H if the child has a history of that problem (Check all that apply):

| | | | | | |
|---------------------------------------|--------------------------|--|---|-------------------------------|------------------------------|
| C | H | C | H | C | H |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Suicidal ideation with intent or plan | Substance abuse | Behavior that has caused physical harm to others | Suicide attempts | Sexual promiscuity/acting out | Legal Issues |
| Self-damaging acts | Appetite/eating problems | Family Issues | Aggressive behavior | Sleep problems | Developmental Issues |
| Isolative behavior | Encopresis/Enuresis | Educational Issues | Social stressors with a lack of support | Symptoms of psychosis | Depression |
| Impulsivity and/or judgment problems | Fire setting | Anxiety-related problems | Serious or chronic physical illness | Suspected/confirmed abuse | Other (Please specify below) |
| School truancy | Cruelty to animals | <input type="checkbox"/> | Running away | Homicidal ideation | <input type="checkbox"/> |

Summary of current psychological and/or behavioral issues (use additional pages if necessary):

Following Evaluations that have been performed (Check all that apply):

| | | |
|--------------------------|--------------------------------|-------------|
| <input type="checkbox"/> | Chemical Dependency Evaluation | Date: _____ |
| <input type="checkbox"/> | Neuropsych. Evaluation | Date: _____ |
| <input type="checkbox"/> | Psychosexual Evaluation | Date: _____ |

DSM IV or DC:0-3 Diagnosis (if available) Please include all 5 axes:

Diagnosed by: _____ Date: _____

Type of provider making diagnosis: _____

Have medications been prescribed? Yes No

If yes, please specify medication, dosage, length of time prescribed, and prescribing physician/phone numbers:

Other medical concerns: _____

Intervention History (please attach relevant clinical information):

Please check all that apply and list most recent dates:

- | | | | | | | | | | | | | | | | | | |
|---|---|---|--|--|--|---|---|---|--|--|---|---|---|---|--|--|--|
| <input type="checkbox"/> Case Management Services Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Residential Treatment Center Location: _____ Dates: _____ - _____ Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> In Home Services Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Partial Hospitalization Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Outpatient Drug and Alcohol Treatment Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Therapeutic Foster Home Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Inpatient Psychiatric Hospital Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Detention Center Location: _____ Dates: _____ - _____ | <input type="checkbox"/> Medication Management Services Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Outpatient Therapy Services Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Day Treatment Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Therapeutic Group Home Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Shelter Care Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Inpatient Drug and Alcohol Treatment Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Sex Offender Treatment Location: _____ Dates: _____ - _____ Court Decision? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Correctional Center Location: _____ Dates: _____ - _____ | <input type="checkbox"/> Other (specify) _____ Location: _____ Dates: _____ - _____ | <input type="checkbox"/> Other (specify) _____ Location: _____ Dates: _____ - _____ |
|---|---|---|--|--|--|---|---|---|--|--|---|---|---|---|--|--|--|

Educational Information:

School: _____ Grade: _____ Retained: _____

Special Education Yes No Special Education Disability Category: _____

Other Concerns (use additional pages if necessary):

List the individuals the family is working with who should be part of the Individual Care Coordination Team (i.e. School Counselor, Therapist, Probation Officer, etc.)
