

## Wraparound Referral

Referred by: \_\_\_\_\_ Referral Date: \_\_\_\_\_

Youth Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Youth Placement: \_\_\_\_\_ Phone (if different): \_\_\_\_\_

I have consulted with the family/guardian about this referral and they agree:  YES  NO

OHP member

Currently enrolled in services with Compass Behavioral Health

Therapist: \_\_\_\_\_

---

### Receives services from a child serving agency other than Mental Health (check all that apply):

Special Education (IEP)       Juvenile Justice/OYA       DHS Child Welfare       Residential Placement   
Substance Abuse/Addictions       Intellectual/Developmental Disabilities       Complex Medical Needs       Other (detail below)

---

### Demonstrates Social, Emotional, or Behavioral issues (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> Threats of harming self or others                          | <input type="checkbox"/> History of Substance abuse |
| <input type="checkbox"/> Significant risk of losing placement/Placement disruptions | <input type="checkbox"/> Aggressive behaviors       |
| <input type="checkbox"/> Significant decrease in functioning                        | <input type="checkbox"/> Sexualized behaviors       |
| <input type="checkbox"/> Recent Hospitalization (ER, Acute, or Sub-acute)           | <input type="checkbox"/> Family issues              |
| <input type="checkbox"/> Residential Facility (BRS or PRTS)                         | <input type="checkbox"/> Other _____                |

**Reason for referral:**

Strengths of youth/family:

Barriers:

Other Information/ Notes: