Sandusky County Family & Children First Council

Wraparound Referral

Date: _____

Identified Youth's Name	DOB	Race	Ethnicity	Gender	Adopted Y or N	Previously involved in Wraparound (Y or N)

Referred By: Relationship to child:

Email: Phone:

Has the parent/guardian been informed you are making the referral: ☐ Yes ☐ No

Briefly describe the reason for referral. What would you like to accomplish?

Strengths of the Youth and Family:

School	Grade	Educational Placement: (i.e. regular ed, special ed, home schooled etc.)

Is the youth on an IEP? ☐ Yes ☐ No Preferred Language: _____

Guardian Name:			Guardian Name:		
Relationship to youth:			Relationship to youth:		
Race:	Ethnicity:	DOB:	Race:	Ethnicity:	DOB:
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Preferred Phone:			Preferred Phone:		
Email:			Email:		

Biological Parents' Names (if different than guardians): _____

Other household members:	DOB	Relationship	Adopted Y or N	Race	Ethnicity	School	Grade

Does youth have Medicaid? ☐ Yes ☐ No Name of Managed Care Plan:_____
Does youth have Private Insurance? ☐ Yes ☐ No Name of Provider: _____

Primary Care Physician's Name: _____

Is youth in need of a Primary Care Physician? ☐ Yes ☐ No

Is youth currently out of the home (hospital, detention, treatment facility)? ☐ Yes ☐ No

If Yes, complete the following:

Placement:	Contact:
Address:	Phone:
City: State: Zip:	Email:

Please indicate the child's involvement in the following systems.

Current	History	System	Reason for Involvement	Provider Name(s)/Role(s)
☐	☐	Board of DD		
☐	☐	Children Services		
☐	☐	Special Education		
☐	☐	Job and Family Services		
☐	☐	Mental Health		
☐	☐	Juvenile Court		
☐	☐	Substance Abuse Addiction Services		
☐	☐	Hospital		
☐	☐	Early Intervention/HMG		
☐	☐	Other:		

If court involved, check if the court has found the youth: ☐ Unruly ☐ Delinquent (criminal offense if an adult)

Behavioral Health Diagnoses: _____

Current Medications: _____

Check if History of Abuse: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect
Reports of sexual and/or physical abuse of the youth, **past or present.** (Professional must follow duty to report mandate if this event has not already been reported)

********** **For Agency Use Only** **********

Referral Outcome:		Follow-up Call:		Intake/Assessment Set
		Contact Letter Sent:		Referred To Other Services
		Does Not Want Services		No Response Received

☐ I & R ☐ Service Coordination ☐ High Fidelity ☐ Denied

Assigned to: Date:

NOTES: