Crossroads Counseling Center

JANESVILLE OFFICE

17 S. River Street, Suite 254

Janesville, WI 53548

Phone: 608-755-5260 Fax: 608-755-5267

SUN PRAIRIE OFFICE

722 Lois Drive

Sun Prairie, WI 53590

Phone: 608-837-9112 Fax : 608-837-9191

Thank you for the recent referral to Crossroads Children/Adolescent Day Treatment Program. We are sending you a referral form that we will need to have filled out and faxed back to us prior to scheduling an assessment appointment.

This referral form is part of Crossroad's new process for our programs. Once the referral form is returned, it will be reviewed and help determine the eligibility of the child/adolescent for the program. If eligible, an assessment appointment can be scheduled.

If you have questions, please feel free to contact us at 608-755-5260 or 608-837-9112.

Thank you for your time.

Crossroads Counseling Center

CrossRoads Children /Adolescent Day Treatment Referral Form

Janesville Office--Phone (608) 755-5260 Fax (608) 755-5267
Sun Prairie Office—Phone (608) 837-9112 Fax (608) 837-9191
Please fax completed form to the appropriate referral location

Child/Adolescent Name: _____ **DOB:** _____

Insurance Source: _____ **School:** _____

Parent/Guardian name: _____ **Phone:** (____) ____-____

Parent/Guardian mailing address: _____

Referring Licensed Therapist: _____ **Phone:** (____) ____-____

Reason for Referral: Provide details of all treatment history for the past year, to include treatment level of care, (Outpatient, Intensive Outpatient, Group, In-home family therapy, Hospitalizations, Day Treatment, Residential Treatment) specific treatment goals and outcomes, first and last names of providers and treatment outcomes (refer to DHS 40.08(3) on back side)_____

_____

_____

_____

_____

_____

Current treatment providers, treatment goals and interventions utilized and progress to date to include approximate duration and number of individual, group and family sessions: _____

_____

_____

_____

_____

Are additional community resources/services involved? _____ IEP, _____CPS, ____CST, ____Probation, _____Other

_____

Have you considered levels of care other than CADT? **Yes / No** – If yes which? _____

_____

Has the child ever received a developmental diagnosis? **Yes /No**

Last Psychiatric Evaluation completed by: _____ Date: _____

Primary Physician:_____ Clinic:_____

Medication History/ Side effects: _____

_____

_____

Current Medications and Provider: _____

_____

_____

History of known treatment providers and treatment modalities (prior to past year)_____

_____

Based on the information you have at present do you believe the child you have referred for Day Treatment meets all of the following criteria as outlined by DHS 40.08 (3) ***see below****.*

Criteria for Admission DHS 40.08(3)

For a program to admit a child:

1. The child shall have a primary psychiatric diagnosis of mental illness or sever emotional disorder (this diagnosis should be obtained from a licensed psychiatrist, MD or PhD) **Yes / No**

2. The child shall be unable to obtain sufficient benefit from a less restrictive treatment program; **Yes /No**

3. Based upon the information available at the time of the referral, there shall be a reasonable likelihood that the child will benefit from the services being offered by the program. **Yes / No**

Based on the information you have at present do you believe the client you have referred for Day Treatment meets the following criteria:

A. Be exhibiting significant dysfunction in 2 or more of the basic domains of his or her life requiring the services offered by the program in order to acquire or restore the skills necessary to perform adequately in those areas; **Yes / No**

B. Be in need of a period of transition from a hospital, residential treatment center or other institutional setting as part of the process of returning to live in the community; **Yes / No**

C. Be experiencing a period of acute crisis or other severe stress, so that without the level of services provided by the program, he or she would be at high risk of hospitalization or other institutional placement; **Yes / No**

Information provided is essential to completion of this child's assessment process for prompt and proper placemer determination.

Form completed by:

_____ _____
Printed name Contact number

_____ _____
Signature Date

Internal Office use only please

□ Approved
□ Denied (Additional information required)
□ Does not meet DHS 40.08(3) criteria for admission

Therapist: _____ Date: _____

□ Parent/Guardian called to schedule appointments □ Paperwork and releases mailed

Support staff initials : _____ Date: _____

(Part one of a Two Part Process)

N:tina/adolescentdaytreatmentreferralform