Transitional Living Services of Northern New York
482 City Center Drive, Watertown, New York 13601
(315) 782-1777 Fax (315) 785-8628
E-mail: services@tlsnny.com
Stevie Smith, Executive Director

- For Community Residence referrals attach a copy of the most recent psychiatric assessment, Physical, Immunization Record, IEP, and any psychological reports on the child.

Children and Youth Program
Referral Form

Name:______________________________ Sex:__________

Date of Birth:__________________ Place of Birth:__________________

Identified Cultural Background:____________________________

Is the child in DSS Custody: Yes ________ No______

Name and Address of Parents/Guardian:____________________________

______________________________ Phone:____________

Religion:____________________ Social Security Number:________________

Medicaid Number:________________ Other Insurance:__________________

Current Living Arrangement and Length of Stay: (If in hospital, state circumstance prior to admission and admission date.) ____________________________

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History of Hospitalization:________________________________

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Family Interest (Interest shown by significant others):____________________

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Caseworker or Primary Therapist:____________________________

Psychiatric (DSM-IV) Diagnosis: Axis I: ____________ Axis I: ____________

Axis II: ____________

Axis III: ____________

Axis IV: ____________

Axis V: ____________

Date of Diagnosis:________________________________

Current Medications:________________________________

Current Primary Physician:____________________________

Address:____________________________ Phone:____________

Physical Conditions: Specify if there are any physical problems, diabetes, epilepsy (type and frequency of seizure), allergies, special diet, etc. List all disabilities and impairments (speech defects, hearing).

Date of Last Tetanus Immunization:

Any History of fire setting or cruelty to animals? Explain. Any legal involvement? Explain.

Any history of abuse? Explain.

Home School District and Address:

Current Educational Level:

Any Current Treatment Program:

Treatment Recommendations for Community Follow-up:

Summary:
The summary should include such information as: behavioral problems, special fears of resident, special strengths, temper tantrums, history of enuresis, etc. State eating, sleeping, peer relating, and studying habits. Please state why you feel that this child needs community residence placement:

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THIS REFERRAL SHOULD BE ACCOMPANIED BY THE FOLLOWING RECORDS: PSYCHIATRIC EVALUATION, PSYCHOLOGICAL TESTING, PSYCHOSOCIAL HISTORY, RECORD OF A PHYSICAL AND IMMUNIZATION, EDUCATIONAL SUMMARY, AND CURRENT IEP IF IN SPECIAL EDUCATION

Referred by:____

Agency:____

Phone:______________________ Date:____

Note: This completed form will be screened by North Country Transitional Living Services, Inc. Admissions Committee. Further information may be requested.

Transitional Living Services of Northern New York
Children and Youth Program
Request for Admission and Consent for Release of Information

Name of Child: ____

Current Address: ____

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I am requesting that my child's referral packet be submitted to North Country Transitional Living Services, Inc. (NCTLS) and its Admission Committee to determine eligibility for the Children and Youth Residence. I understand this committee will be made up of representatives from the community and could include people from schools, St. Lawrence Psychiatric Center, other children's residential programs, Social Services, the referral source, and/or other agencies within the community. I also understand that I can participate if I choose to do so. I give my permission for this community to give and receive information regarding my child.

I understand the referral packet will be checked for completeness. NCTLS may need to contact me or the referral source for further clarification or to request additional documentation.

I believe my child qualifies for the residence because he:

Has attained the age of 12 but not 18;

Has a designated mental illness diagnosis;

Has a substantial problem in social functioning due to a serious emotional disturbance within the past year which could include problems within the family, with peers, and/or in school;

Has serious and persistent symptoms of cognitive, affective, or personality disorders; and

Has a level of service need which requires multi-agency intervention and involvement.

I understand this screening is necessary to determine eligibility for residential services, but it does not constitute acceptance into the program.

Parent/Guardian Signature:____

Parent/Guardian Name (print):____

Date:____

INITIAL Authorization
for
Restorative Services of Community Residences
in

Children's Congregate Residences

Transitional Living Services of Northern New York
482 Black River Parkway
Watertown, NY 13601

Initial Authorization for the receipt of Restorative Services not to exceed 6 months.

CLIENT'S NAME: ______________________________

CLIENT'S MEDICAID #: ______________________________

I, the undersigned licensed physician, based on my review of the assessments made

available to me, and having conducted a face-to-face assessment with said client as

required pursuant to Part 593 of Title 14 NYCRR, have determined that

______________________________ **would benefit from the**
(Client's Name)
provision of mental health restorative services as known to me and defined pursuant to

Part 593 of

Title 14 NYCRR.

______________ ______________________________
Month/Day/Year **Physician's Signature**

______________ ______________________________
License Number & State **Type or Print Physician's Name**

01/03/2012 #140a (IniAuthCRchild:forms)