



Transitional Living Services of Northern New York

482 Black River Parkway, Watertown, New York 13601

(315) 782-1777 Fax (315) 785-8628

E-mail: [services@tlsnny.com](mailto:services@tlsnny.com)

Stevie Smith, Executive Director

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.) \_\_\_\_\_

History of Hospitalization: \_\_\_\_\_

Family Interest (Interest shown by significant others): \_\_\_\_\_

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).

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Date of Last Tetanus Immunization: \_\_\_\_\_

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

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Any history of abuse? Explain. \_\_\_\_\_

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Home School District and Address: \_\_\_\_\_

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Current Educational Level: \_\_\_\_\_

Any Current Treatment Program: \_\_\_\_\_

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Treatment Recommendations for Community Follow-up:

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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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am requesting that my child's referral packet be submitted to Transitional Living Services of Northern New York (TLS) 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. TLS 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 within the previous six months with said client as required pursuant to Part 593 of Title 14 NYCCR, 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**

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(rev.9/09)

(cyp/forms/referral)