Children's Crisis Residence Referral Application

Please complete this referral application and submit the referral to childrenscrisisresidence@ican.family. Referrals can be made by Service Providers and/or Parent/Legal Guardian. Please note that this email is under 24/7 monitoring, and our Children's Crisis Residence Staff will respond within a timely manner. If a case consultation is needed immediately, please contact our Children's Crisis Residence main line at 315-801-7329 and follow the prompts for referral services.

Admission Criteria:

- Children ages 5-19 can be referred to the crisis residence. If a child is not appropriate for admission, our team will assist the family in connecting with resources in the community, including mental health services available through ICAN.
- The child/youth is experiencing acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it; AND
- The child/youth demonstrates at least one of the following:

  - Impairment in mood/thought/behavior disruptive to home, school, or the community.
  - Behavior escalating to the extent that higher intensity services will likely be required.
  - The intervention is necessary to further evaluate, resolve, and/or stabilize the child/youth.
  - The child/youth is not at imminent risk of harm to self or others.

If this is an immediate emergency and you fear your youth may be at risk, please contact 911.

For general information please contact:

Stasia Darling, Children's Crisis Residence Program Manager
Office Line: (315) 922-8628
Email: sdarling@ican.family

Carrie Conte, Director of Crisis Services
Office Line: (315) 731-2689
Fax: (315) 731- 5620
Email: cconte@ican.family

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YOUTH'S INFORMATION:

Name:	Date of Birth:	Ethnicity:	Primary Language:	Gender:
Address:				
SS#:	Medicaid#:	Insurance Name:		
Private Insurance Name:		Private Insurance #:		
Parent/ Legal Guardian Name:		Parent/Legal Guardian Address (if different):		
Home phone:	Cell Phone:	Work Phone:		

EMERGENCY CONTACTS (at least 3 are required):

Name	Relationship	Address	Phone

REFERRING INFORMATION:

Name of the Individual making the Referral:	Agency/Service Provider:	Role/Title:
Address:		
Phone:	Fax:	Email:
Signature:	Date:	

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Presenting Problems: (What factors contribute to the youth being at risk of an ER visit or Hospitalization due to Mental Health Crisis):

SIGNIFICANT BEHAVIORS CHECKLIST:

Please check off any behaviors that your child has exhibited in the past 3-6 months:

LETHALITY	MENTAL HEALTH	SEXUALIZED BEHAVIORS	SAFETY & RISKS NEEDS
☐Fire setting ☐Bed wetting/soiling (specify) ☐Stealing ☐Hurts animals ☐Physically Aggressive ☐Running away ☐Impulsive ☐Oppositional/Defiant ☐Lying/Story telling ☐Peer Issues ☐Substance Abuse ☐Other:	☐ Inability to Regulate Emotions (uncontrollable crying, anger, or shutting down). ☐ Health related disease or diagnosis that may impact their Mental Health. ☐ Depressive symptoms ☐ Self-injurious Behaviors ☐ Eating disorders ☐ Sleep disorders ☐Hallucinations/delusions ☐ Suicidal ☐ Other:	☐Sexually reactive ☐Sexually aggressive ☐Inappropriate contact with another individual(s). ☐Other:	☐Safety plan required ☐Involvement with criminal activity ☐Has been incarcerated or placed in a residential setting. ☐Drug/Alcohol abuse ☐Other:

Please provide details to any items checked off above:

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YOUTH'S MENTAL HEALTH OR SERVICE PROVIDER INFORMATION (If Any):

Psychiatrist:	Agency/Service Provider:	Address:	Phone:	Fax:
Diagnosis:		Medication:		

Please list any previous service providers in this section:

Agency: Contact Information:

Agency: Contact Information:

Agency: Contact Information:

YOUTH'S MEDICAL INFORMATION:

Primary Care Physician:	Address:	Phone:	Fax:

Please select any that apply to the youth's medical information:

☐Exposure to contagious disease (MRSA, etc.): Yes ☐ or No ☐, If yes explain:

☐Medical problems: Yes ☐ or No ☐, If yes explain:

☐Dietary restrictions

☐Physical handicap

☐Infectious disease

☐Failure to thrive

☐Any medical restrictions

☐Does the youth have any allergies?

Describe any on-going medical needs/concerns (asthma/seizures/heart conditions/diseases etc.):

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Educational Information:

School and Grade:	Address:	Phone:
Guidance Counselor:	School Social Worker or Clinical Care Coordinator (please specify):	Teacher:
Does the Youth have an IEP? ☐Yes or ☐No If Yes, What Classification:	Does the Youth have a 504 Plan? ☐ Yes or ☐ No If Yes, What Circumstances:	Any Educational Comments or Concerns:

Parent/Legal Guardian (**Note:** Parent/Legal guardian can make a referral without a service provider):

Parent/Legal Guardian:	Relationship to the Youth:
Phone:	Fax (If any):
Address:	Email (If any):
Parent/Legal Guardian Signature:	Date: