

## Respite Referral Program Referral Form

Baltimore County Department of Health  
 Bureau of Behavioral Health/Core Service Agency (CSA)  
 6401 York Road, 3<sup>rd</sup> Floor  
 Baltimore, MD 21212  
 410-887-2731  
 Fax 410-887-3786  
 Attn: Kina DeWitt  
**For youth with Medical Assistance only**

### AGENCY INFORMATION:

Referral Date: \_\_\_\_\_

Referring Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Position of person completing this Form: \_\_\_\_\_

Relationship to Child/Adolescent: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Type of Respite Requested:

- In-home/community (Up to 8 hours per month for up to 12 months)  
 Out-of-home (Up to 2 weekends per month for up to 12 months. Child spends 1-2 weekends per month in the home of a therapeutic foster family.)  
 How Often? \_\_\_\_\_

### CHILD/ADOLESCENT INFORMATION:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  Female  Male Race:  African American  Caucasian  Other

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MA#: \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Child currently resides with:  Parents  Mother  Father  Other: \_\_\_\_\_

Address: \_\_\_\_\_, MD Phone: \_\_\_\_\_

List household membership/relationship/age:

\_\_\_\_\_

\_\_\_\_\_

Legal Custody/Guardianship: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_, MD Phone: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name, Address, Phone of Current Mental Health Providers: \_\_\_\_\_

**Most Recent Diagnoses:**

Axis I: \_\_\_\_\_ - \_\_\_\_\_

Axis II: \_\_\_\_\_ - \_\_\_\_\_

Axis III: \_\_\_\_\_ - \_\_\_\_\_

Axis IV: \_\_\_\_\_ - \_\_\_\_\_

Axis V: Current \_\_\_\_\_ - Highest \_\_\_\_\_

Medications:  None

**Individual Treatment Plan (ITP) goals related to RESPITE care services:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Previous Placements:  Information Not Available

Type	Date	Agency
<input type="checkbox"/> Therapeutic Foster Care		
<input type="checkbox"/> Diagnostic Center		
<input type="checkbox"/> Shelter Care		
<input type="checkbox"/> Psychiatric Hospital		
<input type="checkbox"/> Residential Treatment Center		
<input type="checkbox"/> Detention Center		

**Other Agency Involvement / Relationship:**

DSS

DDA

DJJ

MHA

LEA

Other: \_\_\_\_\_

**CURRENT SERVICES**

Please specify program name, contact name and phone number, if available

PRP: \_\_\_\_\_ Phone: \_\_\_\_\_

TBS: \_\_\_\_\_ Phone: \_\_\_\_\_

Respite: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other: \_\_\_\_\_ Phone: \_\_\_\_\_

**PROBLEMATIC BEHAVIORS/CONCERNS:** (H/O = History of; A=Active)

H/O	A	H/O	A	H/O	A
<input type="checkbox"/> Abandonment issues	<input type="checkbox"/>	<input type="checkbox"/> Oppositional/Defiant	<input type="checkbox"/>	<input type="checkbox"/> Property destruction*	<input type="checkbox"/>
<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/> Phobia (s)	<input type="checkbox"/>	<input type="checkbox"/> Runaway	<input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Psychosis	<input type="checkbox"/>	<input type="checkbox"/> School Problems	<input type="checkbox"/>
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/> Self-Mutilation *	<input type="checkbox"/>	<input type="checkbox"/> Sexually Aggressive *	<input type="checkbox"/>
<input type="checkbox"/> Enuresis	<input type="checkbox"/>	<input type="checkbox"/> Suicidal*	<input type="checkbox"/>	<input type="checkbox"/> Sexually Provocative	<input type="checkbox"/>
<input type="checkbox"/> Hyperactive	<input type="checkbox"/>	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/> Theft	<input type="checkbox"/>
<input type="checkbox"/> Impulsive	<input type="checkbox"/>	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/> Verbally Aggressive	<input type="checkbox"/>
<input type="checkbox"/> Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/> Tantrums	<input type="checkbox"/>	<input type="checkbox"/> Physically Aggressive*	<input type="checkbox"/>
<input type="checkbox"/> Lying	<input type="checkbox"/>	<input type="checkbox"/> Cruelty to Animals*	<input type="checkbox"/>	<input type="checkbox"/> Peer difficulties	<input type="checkbox"/>
<input type="checkbox"/> Mood fluctuations	<input type="checkbox"/>	<input type="checkbox"/> Fire setting*	<input type="checkbox"/>	<input type="checkbox"/> Hallucinations	<input type="checkbox"/>
<input type="checkbox"/> Parental addictions	<input type="checkbox"/>	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/> Seizures	<input type="checkbox"/>
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/> Neglect	<input type="checkbox"/>
<input type="checkbox"/> Other: _____					

Please provide where the behavior has been observed, intensity, frequency, and date of last occurrence for any items marked with an \*: \_\_\_\_\_

Allergies, reactions, and treatment (medicine, food, insects, and plants): \_\_\_\_\_

Physical/emotional health problems that the respite provider should be advised of: \_\_\_\_\_

Other pertinent information: \_\_\_\_\_

\_\_\_\_\_  
Signature (person completing this form)

\_\_\_\_\_  
Date

**PARENTAL/GUARDIAN CONSENT:**

*By signing below, I hereby give the Baltimore County Core Service Agency permission to pursue Respite Care services for my child and to share information with providers.* \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Service Agency Child and Adolescent Program Monitor

\_\_\_\_\_  
Date