Individual, Conjoint, Family, or Group Treatment Referral Form
Child Welfare Services

One Client per Referral Form. SW to complete all pages.

SW INFORMATION

Date:

Name of SW: Phone #: Fax #:

SW Email: Region/Centralized Program: <select> Program: <select>

PSS Name: PSS Phone # PSS Email:

PSS Signature:_____

NOTE to provider: Central # to Locate SW: 858.694.5191 *If you are unable to locate the SW with information provided above.*

TERM website for Initial Treatment Plan/Update report templates: https://www.Optumsandiego.com/portal/server.pt

CLIENT/CASE INFORMATION

Name of Client: Gender: <select> DOB: State ID #: Two Digit Person #:

Language: <select> If client is a child/youth indicate language of their parent/caregiver:<select>

Ethnicity: <select> If "Other, please specify:
Client's/Caregiver's Name and Address (including facility name, if any):
Client's/Caregiver's Phone Number:

☐ Voluntary ☐ Court-Ordered ☐ Pre-jurisdiction Next Court Date: Date submitted to OptumTERM:

Client is being referred for the following modality: <select>

For conjoint treatment referrals:
Mother ☐ has ☐ has not (check one) successfully completed group treatment (list completed services): ☐ N/A
Father ☐ has ☐ has not (check one) successfully completed group treatment (list completed services): ☐ N/A
Child's therapist states child is clinically ready for conjoint therapy ☐ Yes ☐ No ☐ N/A

Transportation issues/limitations:

Scheduling preferences [evenings/weekends only, etc.]

TERM Provider name (if known) :

Safety Threats and Risk Factors (from SDM assessments):

Describe the incident that brought this family to CWS' attention (i.e. The safety concern that resulted in CWS involvement; the Harm Statement):
Date of the incident:

What is going on in the case right now (i.e. Case Plan elements; Danger Statement and Safety Goals):

Why is this service being requested at this time (**INCLUDE** emotional, social, behavioral, developmental concerns for the child/adolescent **OR** specific mental health concerns about the parent):

Other agencies/professionals providing services to client and/or their family system:

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CHECK ALL THAT APPLY:

☐ A CHILD IN THIS CASE IS UNDER 3 YEARS OF AGE: W&I Code 361.5 (a)(2) limits reunification services in these cases to 6 months. However, W&IC 366.21(e) permits services to be extended up to 6 additional months if it can be shown that there is a substantial probability that the child will be returned to the parent/guardian by the end of that time.

☐ Highly Vulnerable Child(ren) Case: A higher-than-average possibility exists of serious re-injury or death to a child. Case may include:

- severe physical abuse, and serious non-accidental injuries to the head, face or torso in children age five years or younger, or children who are developmentally delayed at a functional level of five years or younger.
- child's parent or guardian caused the death of another child through abuse or neglect
- infant born to parents currently involved with CWS or pas involvement with CWS and did not successfully reunify

REMINDER: Interns and provisional providers are not permitted to see clients in cases designated as Highly Vulnerable Child(ren) Case (includes cases in which a 300e petition or 300f petition was filed).

COMPLETE THIS SECTION FOR CHILD/ADOLESCENT REFERRAL

REASON FOR REFERRAL:

☐ **Serious Emotional Damage.** A petition has been, or will be, filed under Section 300(c) (Serious Emotional Damage) and CWS would like a licensed mental health professional to assess for the effects of abuse and/or neglect on the child.

☐ **Child is a sexual abuse victim or has witnessed or otherwise been exposed to age-inappropriate or adult sexual behavior.**

☐ **Emotional Abuse** due to exposure to domestic violence.

☐ **Severe Emotional Abuse, Physical Abuse, and/or Neglect.** Child may have been tortured. Specific allegations/true findings :

☐ **Emotional Abuse, Physical Abuse, and/or Physical Neglect.** Child is either living with biological parent or with substitute caregiver (e.g. foster parent, NREFM) and there are behavioral and/or emotional issues.

☐ **Adoption/Termination of parental rights.** The child will not be reunifying with his/her parent(s). An opportunity to process grief/loss issues is appropriate.

☐ **Child recently changed placement.** An opportunity to process grief/loss issues is appropriate.

☐ **Prior therapist terminated services prior to the completion of therapy.**

☐ **The child exhibits significant behavioral concerns:**

- ☐ Self-harming behaviors and/or suicidal ideation, plan, and/or past suicide attempts
- ☐ Sexual Behavior Problems (SBP)
- ☐ **VERIFIED** willful cruelty to animals
- ☐ Physical aggression toward peers and/or caregivers.

☐ **Conjoint or Family Therapy** is recommended by Child's Therapist or SW to facilitate child's therapeutic healing process.

SW to provide the following REQUIRED information:

Mental health diagnoses given by licensed mental health providers in the past:

Current and/or past mental health treatments (e.g. inpatient hospitalizations, outpatient treatment):

Medication(s) – past and current:

School aged child: Current grade School IEP? Yes ☐ No ☐

NOTE TO PROVIDER REGARDING TREATMENT GOALS FOR CHILDREN/ADOLESCENTS

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Therapeutic intervention in individual, conjoint, or family treatment should address the following general components, as specified by the treatment goals and methods used. Please address these components in your initial treatment plan and updates. If any is not applicable, please indicate in your report:

- **Safety** - Assessing child's sense of safety; providing sense of safety in therapy; developing safety plan; enhancing emotionally safe contacts and connections for the child in her/his community
- **Assessing and building on child's emotional, behavioral, psychological strengths** – enhancing resilience
- **Development of improved emotional and cognitive self-regulation -** as evidenced in decreased agitation, depression, anxiety and improved attention, concentration, and behavioral control
- **Developmentally-appropriate means for processing traumatic material**.
- **Enhancing caregiver awareness of child's emotional cues and/or miscues** - how caregiver can interact appropriately and provide a calm, consistent, structured, nurturing environment.

COMPLETE THIS SECTION FOR PARENT REFERRAL

Date by which parent must demonstrate substantial progress in services:

Has the parent threatened CWS staff or others (Restraining Orders? Propensity for violence?):

Client: ☐ Denies allegations/true finding
☐ Accepts responsibility/true finding

REFERRAL FOR GROUP TREATMENT:

☐ Domestic Violence (☐ offender ☐ victim)
☐ Sexual Abuse (☐ offending parent ☐ non-protecting parent)
☐ Child Physical Abuse Group (☐ offending parent ☐ non-protecting parent)

OR

REFERRAL FOR Individual, Conjoint, or Family Treatment. Reason(s):

☐ **Individual Treatment Recommended by Group Facilitator because:**
- ☐ Parent has other significant emotional issues/concerns *pertaining to the protective issues* that make him/her inappropriate for group at this time or that require additional, individual treatment to address
- ☐ Parent's behavior is inappropriate or otherwise disruptive to the group

☐ **Individual Treatment to Address Serious Mental Illness.** Parent has a documented history of serious mental illness (SMI). Development of relapse prevention plan is indicated.

☐ **Individual Treatment because SW Suspects Mental Health Concerns.** Parent does not have a diagnosed history of mental illness but self-reports depression or other significant mental health concerns that are not due to CWS involvement, self-reports suicidal or homicidal ideation **and/or** other mental health concerns (e.g., severe hoarding, hearing voices) that directly impact parent's ability to safely parent.

☐ **Substance Abuse Treatment (SAT) Recommendation.** Parent active to SAT; treatment recommendations include individual therapy for these specific reasons/issues:

☐ **Domestic Violence Conjoint Treatment. AFTER** successfully completing DV offender or DV victim group therapy. NOTE: Conjoint Therapy is NOT a required case plan element in domestic violence cases.

☐ **Conjoint or Family Treatment is Recommended by Child's Therapist or SW.** to facilitate child's therapeutic healing process.

SW to complete the following REQUIRED information:

Mental health diagnoses given by licensed mental health providers in the past:

Current and past mental health treatments (e.g. medications, inpatient hospitalizations, outpatient treatment):

Current and past substance abuse/dependence including drug(s) of choice, current use, past treatments, and response to treatment:

Level of motivation/compliance regarding this service:

NOTE TO PROVIDER REGARDING TREATMENT GOALS FOR PARENTS

The behaviors described below correlate with successful reunification. Treatment goals developed by the provider and parent should promote the behaviors below. By participating in the service, the parent should be able to spontaneously describe the application of, and/or be able to behaviorally demonstrate how s/he:

- Demonstrates parental role: understands role regarding protecting child and keeping child safe.
- Demonstrates knowledge of child's development.
- Demonstrates ability to respond appropriately to child's verbal/non-verbal signals.
- Puts child's needs ahead of her/his own.
- Shows empathy toward child.

****ACTION REQUIRED BY SW****

Submit the 04-176A and 04-130C to Regional JELS Staff to submit to Optum TERM. Optum TERM will forward to provider with the CWS authorization.

***Send case records to the provider** as per the Policy Manual:*
Mental Health Treatment