

KAIROS REFERRAL FACE SHEET

Service Requested: Psychiatric Residential Treatment Psychiatric/Residential Respite TFC
 Day Treatment ICTS Young Adult Program Outpatient

Youth's Name: _____ **Date of Birth:** _____ **Referral Date:** _____

Gender: M / F **Marital Status:** S / M / D / W **County of Origin:** _____

Original Referral Source: _____ **Phone:** _____

Client's Legal Status: Ward of the State Voluntary Civilly Committed/TVA OYA **JJIS # :** _____

Social Security Number: _____ **Race/Ethnicity:** _____ **Religion:** _____

Legal Guardian DHS OYA Other : _____ **Phone:** _____

Caregiver Name: _____ **Relationship:** _____ **Phone:** _____

Caregiver Address: _____

Client's Current Placement and Address: (if different) _____

Client's Current School Placement _____ **Last Grade Completed** _____

Medicaid/OHP/Prime Number: _____ **MHO:** _____

Private Insurance: _____ **ID Number:** _____

Hep B Status: positive / negative **date:** _____ **TB Test Results:** Positive / Negative **date:** _____

SSI / SSD: Yes No **Advanced Directive:** Yes No **Mental Health Directive:** Yes No

TRAUMA HISTORY:

PREVIOUS BEHAVIORS:

- | | | |
|--|--|---|
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Animal Cruelty/Abuse | <input type="checkbox"/> Developmentally Disabled |
| <input type="checkbox"/> Exposure to domestic violence | <input type="checkbox"/> Drug &/or Alcohol Involvement | <input type="checkbox"/> Fire Setting |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Runaway | <input type="checkbox"/> Self Harm |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Sexual Aggression | <input type="checkbox"/> Sexual Reactivity |
| <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Violent Behaviors | |

_____ **Number of prior out-of-home placements**

_____ **Number of prior psychiatric hospitalizations**

_____ **Known or estimated IQ**

AXIS I Diagnoses: _____ **CGAS/GAF score:** _____

Treatment Considerations (what does the team want this client to accomplish during his / her stay?):

Referring Party (please print): _____ **Phone:** _____

Agency: _____ **Date:** _____

KAIROS

Authorization for Release of Information

We can help you better if we are able to work with other professionals and organizations that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

I authorize Kairos to share information about:

Name: _____ D.O.B.: _____ ID #: _____

with the following individuals or agencies:

including records of: (Please *initial* each item)

Family History:	___ Yes ___ No	Medical/Psychiatric Treatment:	___ Yes ___ No
Employment/Unemployment:	___ Yes ___ No	Mental Health Services:	___ Yes ___ No
Educational Reports:	___ Yes ___ No	Other, as listed:	_____
Alcohol/Drug Treatment:	___ Yes ___ No		_____

Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis. Educational records include both behavioral and progress reports.

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstances. ___ Yes ___ No (Please *initial*)

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes as specified: _____

This permission is good until 180 days following discharge from all Kairos programs: _____ (Please *initial*)

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

Parent or Guardian

Date

Client

Date

Kairos Representative

Date

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.

This is a true copy of the original authorization document _____

Kairos Representative