Gateway-Longview Children & Family Treatment & Support Services Referral (CFTSS)

How to make a Referral:

Complete this referral form and send to:
Kristin Clamp, CFTSS Supervisor
10 Symphony Circle, Buffalo, NY 14201
kclamp@gateway-longview.org **(p) 783- 3100 ext 3113 (f) 783-3130**

Referral Source Information

Referral Source Name: ________________________________	Date of Referral: _________________________
Organization: _______________________________________	Department: _________________________
Email: ____	Phone: ________________________________

Client Information

Child's Name: ____________________________________ DOB: ___________________ SSN#: __________________________

Gender: M F T Fluent in English? ___Y ___N Interpreter required? ___Y ___N

Current Address: ____________________________________ City: _________________ Zip: ________________________

Guardian Name #1: ______________________________________ Phone #: _________________________________

Legal Custody Status:

__both parents together	__Joint Custody
__Biological mother only	__ DSS
__Biological father only	__Adult Sibling
__Adoptive Parent	__Other Legal Guardian (Describe)

Current providers:

School/District and Grade:____

Therapist/Therapist Agency____

Psychiatrists/Psychiatrist Agency ____

Is the client currently enrolled in any of the following services:
____ Currently in a Residential Setting
____ Currently enrolled and receiving OPWDD Services
____ Care Coordination / WRAP
____ Health Homes
Other: ______________________________

Risk Factors - Check All that Apply

___Suicide Ideation/ History
___Homicidal Ideation / History
___Repeat ED or Inpatient visits
___Violent behaviors
___Has recently been released from incarceration, placement, detention, or psychiatric hospitalization

Other: ______________________
___Drug use/History
___ Self-Injurious Behaviors

Insurance Information

Insurance company name: ______________________________________ County of Residence: _______________

Insurance ID #: _______________________________ Medicaid ID / CIN #: ____________________

__Other Licensed Professional (OLP)	___Community Psychiatric Support and Treatment (CPST)/Psychosocial Rehabilitation (PSR) **Please choose one** ____Supportive Counseling ____ Psychoeducation

LIST	Mental Health Diagnosis	DX Code
Primary		
Secondary		
Other		

Areas of Functioning: As a result of the symptoms or diagnosis, the child/youth has functional impairment that interferes with or limits functioning in at least one of the areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms.

CHECK	Domain	Description of Impairment
	Self-Direction	
	Self-Care	
	Family life	
	Social Relationships	
	Symptom Management	
	Behavior Modification	
	Other:	

Please describe why you are requesting these services: (Please provide any further information)

____

____

____

____

Are there any safety concerns for the worker, providing services within the Child's home environment:

____ No

____ YES: Please describe: ____

<u>CPST/PSR services only:</u>

<u> By signing below, I am recommending the above-named individual for Child and Family Treatment and Support Service(s)</u>**

This form can only be signed by a Licensed practitioner of the Healing Arts; Registered Professional Nurse, NP, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, LCSW, LMFT, LMHC, or Physician.

_______________________________ _________________________ ____________ ______________

** LPHA Signature Printed Name NPI # Date