Referral Information for CADD Day Treatment Program

Date:_____ Referral Completed by:_____
Phone Number:_____
E-mail Address:_____

Student Demographics

Student Name:_____ DOB:_____ Age:_____
Preferred names that the child goes by:_____
SSN:_____-_____-_____ Sex: M / F Height:_____ Weight:_____
Home Address:_____
Home Phone#:_____ Alternative Phone #:_____
Living with:_____
Student's Legal Status: Please check one box below
☐ Minor with guardian ☐ Adult with guardian ☐ Independent Adult
Primary Language Spoken:_____ Interpreter Needed: ☐ Yes ☐ No

Guardian Information

Name:_____ Relationship to Student:_____
Address:_____
Phone # (preferred):_____ Phone # (alternate):_____
Email Address:_____
Primary Language Spoken:_____ Interpreter Needed: ☐ Yes ☐ No

Is there a custody or visitation agreement that we should be aware of? ☐ Yes ☐ No

Co-guardian (if relevant)
Name:_____ Relationship to Student:_____
Address:_____
Phone # (preferred):_____ Phone # (alternate):_____
Email Address:_____
Primary Language Spoken:_____ Interpreter Needed: ☐ Yes ☐ No

School Information

District Name:_____ School Name:_____
Teacher Name:_____ Grade:_____
Teacher Email Address:_____ Phone #:_____

Does child have a current IEP and receive Special Education Services? ☐ Yes ☐ No
Special Education Director Name:_____ Phone #:_____
Sp.Ed.Dir. Email Address:_____
Other District Contact Name:_____ Title:_____
Phone #:_____ Email Address:_____

Insurance Information*

Primary

Company:_____ Phone#:_____
Address:_____
Policy#:_____ Group#:_____
Subscriber Name:_____ SSN:_____-_____-_____
Subscriber DOB:_____ Relation to Student:_____
Subscriber Address (if different from above):_____
Subscriber Employer and Address:_____

Secondary

Company:_____ Phone#:_____
Address:_____
Policy#:_____ Group#:_____
Subscriber Name:_____ SSN:_____-_____-_____
Subscriber DOB:_____ Relation to Student:_____
Subscriber Address (if different from above):_____
Subscriber Employer and Address:_____

*Please note, the purpose of this information is, upon consent, your child's MaineCare will be billed for all clinical services provided as a day treatment student. Similarly, MaineCare requires all insurance information (including commercial insurance).

☐ I give consent to check the status of MaineCare benefits (please check box)

Clinical Information

Presenting Problem - Please check all that apply – (Circle your #1)

□ Anxiety	□ Tantrums	□ Self-Injurious Behavior	□ Aggression
□ Depression	□ Grief/Loss	□ Motor Concerns	□ Regression
□ Sensory Concerns	□ Mood Dysregulation	□ Speech/Communication Concerns	

□ Other: _____

Recent psychological testing? ☐ Yes ☐ No If yes, where, when and by whom:

_____

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

Current Providers:

Psychiatrist/Med Management (current)	_____	Phone #	_____
Psychiatrist/Med Management (past)	_____	Phone #	_____
Pediatrician/Family Physician	_____	Phone #	_____
Developmental Behavioral Pediatrician	_____	Phone #	_____
Psychologist	_____	Phone #	_____
Neurologist	_____	Phone #	_____
Therapist	_____	Phone #	_____
In-home provider/Agency	_____	Phone #	_____
Speech Therapist	_____	Phone #	_____
Occupational Therapist	_____	Phone #	_____
Case Manager/Agency	_____	Phone #	_____
HCT Provider	_____	Phone #	_____

Medical History:

Has your child been diagnosed with any of the following? (Please check all that apply.)

	Diagnosed by whom?	Diagnosed when?
☐ Autism		
☐ Developmental Disorder		
☐ Intellectual Disability		
☐ Anxiety		
☐ ADHD		
☐ Mood Disorder		
☐ Depression		
☐ OCD		
☐ Seizure Disorder		
☐ Other (please list)		

Feeding: Does Student have feeding issues? ☐ Yes ☐ No Describe:_____

_____

Does Student have a history of choking or aspirating? ☐ Yes ☐ No

Communication: Is Student verbal? ☐Yes ☐No

If no, please circle communication used: PECS • Communication Board • Electronic Device • ASL

Sign Language spoken/understood by Student: ☐Yes ☐No by Parent/Guardian: ☐Yes ☐No

Interpreter needed: ☐ Yes ☐ No If yes, what type of services are needed?_____

Recent Speech/Language Evaluation: ☐Yes ☐ No If so, by whom and when? _____

Occupational Therapy:

Does Student have any sensory issues (i.e. food, clothing, loud noises etc..)? ☐Yes ☐No

If so, please describe:_____

Recent Occupational Therapy evaluation? ☐ Yes ☐ No If so, by whom and when? _____

Can Student walk without assistance? ☐ Yes ☐ No

If no, what type of assistance does he/she need? Wheelchair • Gaitbelt • Walker • Other_____

Does Student utilize any protective equipment? ☐Yes ☐No Describe:_____

_____

Self Care Skills:

How much assistance does Student need with:

Eating:	Minimal Assistance	Moderate Assist	Maximum Assist	Total Assist
Dressing:	Minimal Assistance	Moderate Assist	Maximum Assist	Total Assist
Toileting:	Minimal Assistance	Moderate Assist	Maximum Assist	Total Assist
ADL's:	Minimal Assistance	Moderate Assist	Maximum Assist	Total Assist

Behavioral Concerns:

Does Student currently engage in physical aggression? ☐Yes ☐No If so, please describe:

_____

_____

How often (frequency per day, week)?_____ Directed toward whom?_____

When was the most recent occurrence?_____

Does Student punch with closed fists? ☐Yes ☐ No

Has Student ever required a physical restraint? ☐ Yes ☐ No If so, please describe:

_____

_____

Has Student expressed any homicidal ideation: ☐Yes ☐No If yes, please describe:

_____

_____

Has Student expressed any current or past suicidal ideation: ☐ Yes ☐No If yes, please describe:

_____

_____

Any history of running away? ☐ Yes ☐No

Does Student have a sense of safety awareness? ☐Yes ☐ No

Does Student have any history of self-harming behaviors? ☐ Yes ☐No If yes, please describe:

_____

_____

Is there a history of "sexualized behaviors"- including inappropriate touching, sexualized play, grooming of others or violence? ☐ Yes ☐ No If so, please describe:

_____

_____

Does Student demonstrate any of the following (If yes, please describe):

Animal Cruelty ☐ Yes ☐ No _____

Fire Setting ☐ Yes ☐ No _____

Sexual perpetration ☐ Yes ☐ No _____

History of experiencing physical/sexual trauma or exposure to domestic violence: ☐ Yes ☐ No

If yes, please describe:_____

Student's Leisure time:

How does Student like to spend his/her leisure time? _____

_____

Does Student have any favorite characters or security items that are helpful or regulating?

_____

Long-Term Goal:

CADD's mission is to stabilize students and facilitate transition back to the local school setting.

Reason for out of district placement:_____

_____

What are your goals for out of district placement?_____

_____

Have there been any recent changes/losses in Student's life at home/school? ☐ Yes ☐ No

_____

_____

Has Student had any prior out of district school placements? ☐ Yes ☐ No

If yes, where and when? _____

Is the goal that Student will return to their local school setting? ☐ Yes ☐ No

If so, what assistance will be needed to assist in the transition?

_____

If no, what alternatives have been looked at/ what referrals were made?

_____

District, please send the following information:

_____IEP (from school)
_____Psychological Testing (past three years)
_____Occupational Therapy Evaluation (most recent)
_____Speech/Language Evaluation (most recent)
_____Behavior Plan (past or current)
_____Most recent Vineland or ABAS adaptive scores

Parent/Guardian, please provide the following documents:

_____Psychiatric Evaluation/Notes/Meds/Diagnosis
_____Guardianship documents if student is an adult with guardianship or a child with guardianship or shared custody

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Please fax all information to 207-761-0784. For, any questions or concerns please contact Angela Evans at 207-661-3600.