SOUTHEAST CENTER OF EXCELLENCE
REFERRAL FORM

DATE OF REFERRAL 1-28-19 *(One form per child)* **(PLEASE TYPE OR PRINT)**

Child [redacted] [redacted] Serena
Full Legal Name of Client (First) (Middle) (Last Name) Alias, if applicable

DOB: [redacted] **Age:** [redacted] **SS#:** [redacted] Gender: ☐ Male ☑ Female

Race: ☐ Caucasian ☑ African American ☐ Hispanic ☐ Asian/Pacific Islander

Insurance: ☐ TennCare _____ ☑ Private [redacted] ☐ No Ins.

Home County: Hamilton **Name of Current Case Manager:** Patrisha Tatum

E-mail Address ptatum@bethelbiblevillage.org **Work Phone #** (423) 842-5757 Ext. 1231

Fax # (423) 842-5785 **Cell Phone# :** (_____) _____

Team Leader: Robin Moss **Phone#** (423) 842-5757 ext. 245 **E-mail Address** rmoss@bethelbiblevi

Is child in custody? ☐ Yes ☑ No **Date entered Custody:** _____

If not in custody, is there a high risk of removal? ☑ Yes ☐ No Why: _____

If noncustodial, describe current and past prevention programs, if applicable: _____

Legal Issues: _____

Pending Court Dates _____ **Type of Hearing (Purpose)** _____

Name of Attorney or GAL:

Child's Current Placement Information *Please circle one*: **(GH/RTC/FH/Bio.Parents/Kinship/Relative)**

Name/Agency Bethel Bible Village **Address/Phone** 3001 Hamill Rd Hixson, TN 37343 (423) 842-5757

Level of Placement 1 **Placement Contact Person:** Patrisha Tatum **Phone #:** (423) 842-5757 ext. 123

REASON FOR REFERRAL/QUESTIONS YOU WOULD LIKE THE COE TO ANSWER:

Client is having difficulty understanding educational material. Need educational testing done.

Check all that apply

☐ **Medication concerns**

- ☐ Conflicting diagnoses and/or recommendations
- ☐ Need treatment recommendations
- ☐ Multiple placement disruptions
- ☐ Severe problem undiagnosed/being missed (mental health and/or physical)
- ☐ Barriers to permanency (adoption, subsidy, treatment issues)
- ☑ Other Educational Testing

List psychiatric hospitalizations & dates, mental health history and past therapists. (Attach List, if necessary): _____

Medication Information:

Current (Name/Date began/Dose)	Past Trials (Name/Date/Dose)
	Adderall XR 30mg - Discontinued 12/18

Diagnosis Information:

Current	Past
ADHD	

Name of current Therapist: [redacted] **Address** 3001 Hamill Rd. Hixson, TN 37343
Phone: (423) 842-5757 **Fax:** (423) 842-5755

Name of current treating Psychiatrist: _____ **Address:** _____
Phone: _____ **Fax:** _____

Name of Current Treating PCP: [redacted] **Address:** [redacted]
Phone: [redacted] **Fax:** _____

List impairments (vision, hearing, mobility or disabilities): _____

Has this referral been discussed with the family: ☑ Yes ☐ No Last date of contact with family: 1-27-19

EDUCATIONAL INFORMATION

Name of School: Bethel Christian Academy County: Hamilton Current Grade: 5th

Special Education: ☐ Yes ☑ No Certification: _____

The following information will be needed for all COE Referrals:

*Social History or Non-Custodial Assessment *Placement History with dates (include all foster home placements)
*All previous psychological/all psychiatric intakes & progress notes/intake summaries
*Last 3 progress notes from current therapist & treating psychiatrist*Insurance card; Release of Information
*Hospitalizations: Intake Summaries & Discharge Summaries*Permanency Plan/Current Notice of Staffing/IPP *Specialized Evaluations: Psychosexual/Neurological Screenings & Reports*All previous medical assessments: EPSD&T and all medical record *School Records/Academic Testing & IQ Testing/Behavior Records