

**SOUTHEAST CENTER OF EXCELLENCE (SECOE)  
REFERRAL FORM**

**REFERRED BY:** \_\_\_\_\_ **AGENCY:** \_\_\_\_\_

**DATE OF REFERRAL:** \_\_\_\_\_ (One form per child) **(PLEASE PRINT)**

**Child:** \_\_\_\_\_  
Full Legal Name of Client (First) (Middle) (Last Name) Alias, if applicable

**DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **Gender:**  Male  Female

**Race:** Caucasian African American Hispanic Asian/Pacific Islander Other: \_\_\_\_\_

**Insurance:** TennCare \_\_\_\_\_ Private \_\_\_\_\_ None **Home County:** \_\_\_\_\_

**Current FSW/Case Manager:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Work Ph:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_ **Cell:** (\_\_\_\_) \_\_\_\_\_

**Team Leader:** \_\_\_\_\_ **Ph #:** (\_\_\_\_) \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Is child in custody?** Yes No **Date entered Custody:** \_\_\_\_\_

If not in custody, why is there a high risk of removal?: \_\_\_\_\_

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

**Legal Issues:** \_\_\_\_\_

**Pending Court Date(s):** \_\_\_\_\_ **Type of Hearing (Purpose)** \_\_\_\_\_

**Name of Attorney or GAL:** \_\_\_\_\_

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

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Home Ph:** (\_\_\_\_) \_\_\_\_\_ **Cell Ph:** (\_\_\_\_) \_\_\_\_\_

**Level of Placement:** \_\_\_\_ **Placement Agency:** \_\_\_\_\_ **Ph:** (\_\_\_\_) \_\_\_\_\_

**Case Manager:** \_\_\_\_\_ **Ph:** (\_\_\_\_) \_\_\_\_\_ **email:** \_\_\_\_\_

**REASON FOR REFERRAL / Current symptoms and/or behaviors of concern:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_

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

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**Medication Information:**

**Current (Name/Date began/Dose)**

**Past Trials (Name/Date/Dose)**

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**Diagnosis Information:**

**Current**

**Past**

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**Current Therapist:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

**Current treating Psychiatrist:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

**Current treating PCP:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

**List impairments (vision, hearing, mobility or disabilities):** \_\_\_\_\_

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Has this referral been discussed with the family? Yes No Last date of contact with family: \_\_\_\_\_

**EDUCATIONAL INFORMATION**

Name of School: \_\_\_\_\_ County: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Special Education: Yes No Certification: \_\_\_\_\_



**The following information will be needed for all COE Referrals**

\*Releases of Information \*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 \*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 records \*School Records /Academic Testing & IQ Testing/Behavior Records \*Insurance card