



Child & Family Focus, Inc.

Delaware County Respite Referral

Contact Information

Child's Name:		Parent(s) / Guardians:
Date of Birth:		Siblings:
Social Security #:		Home Phone:
Address:	Apt:	Cell Phone:
		Email:

Child Profile

Sex:	Race:	Height/Weight:
Hair Color:	Eye Color:	Religious Preference:

Emergency Contact (not living at child's address)

Name:	Relationship to child:
Address:	Phone #:
	Cell #:

Secondary Emergency Contact

Name:	Relationship to child:
Address:	Phone #:
	Cell #:

Contact Information for Service Provider/Referral Source

Name:	Agency:
Title:	Program:
Address:	Phone:
	Fax:
Email:	On-call #:

School Information

School/Day Program:	School District:		
Contact Person:	Phone:		
Current Grade:	Fax:		
Special Education:	<input type="checkbox"/> Autistic Support	<input type="checkbox"/> Emotional Support	<input type="checkbox"/> Learning Support
	<input type="checkbox"/> Life Skills	<input type="checkbox"/> Other:	

Medical Care Provider Information

Primary Care Physician:	Address:
Phone:	
Hospital Closest to Home:	Address:
Phone:	

Insurance Information

Medical Assistance (MA) #:	Other Insurance Information:
MA Insurance Carrier:	

Diagnoses (Please note that a current Mental Health Diagnosis is needed to receive respite services)

DSM Code:	ICD 10 Code:	DSM 5 Diagnosis:

Family History

Has this family had any police involvement in the past 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has this family ever been involved with domestic violence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the referred child ever been the victim of physical abuse or neglect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the child ever been the victim or perpetrator of sexual abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the family currently have any Children and Youth involvement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you answered yes to any of the questions above please explain:		

Respite Details

Type of respite desired:	<input type="checkbox"/> Hourly - In child's home	<input type="checkbox"/> Overnight - In provider's home	<input type="checkbox"/> Either
Number of Household Pets:	_____ Dogs	_____ Cats	_____ Other: _____
Do you know an individual who can provide respite for your family contingent upon agency approval? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Identified Provider:	Phone Number:		
How does this family envision utilizing respite services (weekends, weekdays, days, evenings, etc.)?			

Crisis Support

The referring agency or family will provide on-call crisis intervention while the child is receiving respite care.
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Exclusion Criteria

Youth referred to respite are required to be psychiatrically stable. Referrals will be reviewed on a case by case basis.
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Transportation

Please note that is the responsibility of the family or referring agency to transport the child to out-of-home respite unless otherwise arranged.

Referral Packet Checklist

<p>The following items are needed to complete a referral for respite services...</p> <ul style="list-style-type: none"><input type="checkbox"/> Respite Referral Form (completed by Mental Health Provider)<input type="checkbox"/> Signed Releases of Information<input type="checkbox"/> Physicians Statement<input type="checkbox"/> Recent Psychological Evaluation or other clinical documentation	<p>Completed Referral Packets may be returned via:</p> <p>Post: Child & Family Focus, Inc Attn: Respite Coordinator 450 Parkway Drive, Suite 208 Broomall, PA 19008</p> <p>Fax: (610) 325 - 3137</p>
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Acknowledgement

By signing below, I acknowledge that this information will be used to find an appropriate respite provider and the information will be released to the respite provider so that they can best meet the needs of this client.		
<i>Signature of Person Completing Form (Mental Health Provider)</i>	<i>Relationship to Child</i>	<i>Date</i>



Child & Family Focus, Inc

Mental Health

AUTHORIZATION TO RELEASE/OBTAIN RECORDS

Administrative Office

920 Madison Ave.
 Audubon, PA 19403
 Phone: 610-650-7750
 Fax: 610-650-7761

Branch Offices

Valley Forge

P.O.Box 365
 11 Davis Road
 Bldg 2, Suite 330
 Valley Forge, PA 19481
 Phone: 610-783-1788
 Fax: 610-783-1944

Hatboro

2935 Byberry Road
 Suite 108
 Hatboro, PA 19040
 Phone: 215-957-9771
 Fax: 215-957-9785

Hatboro Annex

319 South York Road
 Suite A & B
 Hatboro, PA 19040
 Phone: 215-444-0846
 Fax: 215-444-0849

Broomall

450 Parkway Drive
 Suite 208
 Broomall, PA 19008
 Phone: 610-325-3131
 Fax: 610-325-3137

Kennett Square

503 North Walnut Road
 Suite 335
 Kennett Square, PA 19348
 Phone: 484-732-8459
 Fax: 484-732-8495

I hereby authorize, Name of Facility, Agency, or Individual: Child and Family Focus, Inc.		Telephone Number: 610-325-3131
Address: 450 Parkway Drive Suite 208 Broomall, Pa 19008		
To <input type="checkbox"/> release to <input type="checkbox"/> Communicate with <input type="checkbox"/> Obtain from information from the records of:		Date of Birth:
Name of Client:		
For the purpose of: Coordinating Respite Care		
The following Protected Health Information may be released, including information about behavioral/mental health services : (A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion):		
<input type="checkbox"/> Psychosocial History	<input type="checkbox"/> Summary of Treatment	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Medications	<input type="checkbox"/> Psychological Evaluation	
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Discharge Summary	
Please Forward Information to the Attention of, Name of Family, Agency, or Individual Child & Family Focus, Inc. Approved Respite Care Providers		Tel. #: Fax #:
Address:		
City, State and Zip Code:		

I have been told that in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the Facility/Agency/Individual listed above, and will be effective during the dates listed below. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon. (All parts of this form must be completed in compliance with the revised regulations pursuant to the Mental Health Procedures Act).

In the future, if I wish to revoke this consent, I understand that request must be in writing, unless I am physically unable to write.

I understand that this consent form shall remain valid from the date of my signature, beginning on _____ and will expire on _____ (not to exceed 1 year).

NOTICE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records which are protected by state statute. State regulations limit your right to make further disclosure of this information without the prior written consent of the person to whom it pertains. In addition, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The confidentiality of these records is protected under the following provisions of Pennsylvania law and you are responsible for treating these records accordingly: 50P.S. 7111, 71P.S. 1690.108, 4 PA Code 255.5, Pa Code Sections 1101.51, 5100.4, 5100.31, 5100.39, 5200.41, 5210.26, and 5221.52. **If this authorization is requested by someone other than the individual whose Protected Health Information is to be used and/or disclosed:** the requester will sign below and indicate the source of the authority for requesting the release (Child and Family Focus, Inc. will confirm the authority source before using or disclosing the requested Protected Health Information. If there is any question or concern about the authority source of the requestor, please immediately notify Child and Family Focus, Inc. before any use or disclosure is made). A photocopy is as valid as the original.

By signing below, I _____ indicate that I fully understand the information contained in this release of information.

Signature of Client (14 years or older)	Date	Signature of Witness	Date
Signature of Parent/Guardian (if child is under 14 years old or if child is 14-18 year old but denies services)	Date		
Verbal Consent of Parent/Guardian	Date	Name of person who obtained verbal Consent	



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Child & Family Focus, Inc

Mental Health

AUTHORIZATION TO RELEASE/OBTAIN RECORDS TO CFF

I hereby authorize: Name of Current Service Provider:		Telephone Number:
Address:		
To <input type="checkbox"/> release to <input type="checkbox"/> Communicate with <input type="checkbox"/> Obtain from information from the records of:		Date of Birth:
Name of Client:		
For the purpose of: Coordinating Respite Care		
The following Protected Health Information may be released, including information about behavioral/mental health services : (A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion):		
<input type="checkbox"/> Psychosocial History	<input type="checkbox"/> Summary of Treatment	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Medications	<input type="checkbox"/> Psychological Evaluation	
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Discharge Summary	
Please Forward Information to the Attention of, Name of Family, Agency, or Individual		Tel. #: (610)325-3131
Child & Family Focus, Inc.		Fax #: (610)325-3137
Address: 450 Parkway Drive, Suite 208		
City, State and Zip Code: Broomall, Pa 19008		

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Respite Department- Physician's Statement

To be completed by the referred child's primary care physician

This is to certify that _____, to the best of my
(child referred for respite services)

knowledge, is free of communicable diseases.

Physician's Initials _____

Please comment with any medical conditions or concerns that we should be aware of:

Physician's Name (printed): _____

Address: _____

Physician's Signature: _____ Date: _____