# Crisis Stabilization Services Referral Form

NJ Children's System of Care
Contracted System Administrator — PerformCare®

**This referral form is utilized for point in time crisis stabilization services (STAS, CSAP, and ETHP). Refer to Description of Services document for additional information.**

## INSTRUCTIONS:

- Please ensure full, detailed completion of referral form with recent evaluations and discharge summaries in CYBER Document Upload. PerformCare, the CSA, will determine final approval and authorization.
- **All sections of the referral form are required. Please indicate Not Applicable (NA) where appropriate. Incomplete referrals will be returned.**
- For STAS referrals:
  - Referral is to be completed by **CP&P if youth is in CP&P custody or guardianship**. CP&P receives approval from designated CP&P Team Leader and CP&P Central Office Liaison.
  - Referral is to be completed by **CMO for youth only involved with CMO**, including CP&P youth open for services only. CMO request must be approved by a CMO clinical administrator for CSOC-ORS review. Please note for **CMO only referrals**: PerformCare has **1 calendar day** to review the referral.
- For CSAP referrals:
  - Referral is to be completed by CMO or Mobile Response and Stabilization Services (MRSS).
- For ETHP referrals:
  - ETHP is only accessible for CP&P custody youth. Referral must be completed by CP&P team.

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| **Refer to** (select one): ☐ **STAS** ☐ **CSAP** ☐ **ETHP** *(DCP&P custody youth only)* | **Referral Date:** |
| **Youth Name:** | |
| **Preferred Name** (if applicable): | |
| **CYBER ID:** | **County of Primary Legal Residence:** |
| **Sex:** ☐ Male ☐ Female | **Gender Identification:** ☐ Male ☐ Female ☐ Other: |
| **DOB** (MM/DD/YY): | **Age:** |
| **Is youth DD Eligible or pending DD Eligibility?** ☐ Yes ☐ No ☐ Pending – date of application: | |
| **Referent**: ☐ CMO ☐ CP&P ☐ MRSS | |
| **CP&P Involvement**: ☐ None ☐ Custody ☐ Guardianship ☐ Care and Supervision ☐ Open for Services<br>**Date of current involvement**: | |

| **CMO Contact Information** — required, if applicable. | |
|---|---|
| **Care Manager**: | |
| **Email**: | **Phone**: |
| **Supervisor**: | |
| **Email**: | **Phone**: |
| **Clinical Administrator approving referral**: | |
| **Email**: | **Phone**: |

| **CP&P Contact Information** — required, if applicable. | |
|---|---|
| **CP&P Worker**: | |
| **Email**: | **Phone**: |
| **CP&P Supervisor**: | |
| **Email**: | **Phone**: |
| **Team Leader**: | |
| **Email**: | **Phone**: |

| **Youth's Location** | |
|---|---|
| **Where is youth currently** (with family, at resource home, in hospital, etc.)**?** | |
| **Hospitalization:** If the youth is currently hospitalized, please complete the section below. | |
| **What hospital is the youth currently at?** | |
| **Date of admission:** | **Is youth discharge ready from the hospital?** ☐ Yes ☐ No |
| **Has the youth been compliant with prescribed medication regime?** ☐ Yes ☐ No | |
| **List medications and dosage:** | |
| **If PRN prescribed, please specify name/dosage and date last administered.** | |
| **Describe techniques and coping methods used while hospitalized, if applicable.** | |
| **Discharge Summary:** Please provide discharge summary to provider. If previously hospitalized within the last 90 days, please provide discharge summaries to provider prior to initial treatment team meeting. | |

| **Youth Link OOH Referral Status** |
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| **Is youth currently on Youth Link?** ☐ Yes ☐ No |
| If yes, specify youth's intensity of service (IOS), assigned programs, and status of meet and greets. |

| Referral Information |
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| **Reason for Referral:** It is required to provide specific, detailed information related to the youth's behaviors in which crisis stabilization services are being requested. This information will directly benefit the program's understanding of the youth's behaviors and their treatment needs. Any pertinent historical information, if applicable, to support your request can follow. |
| **Barriers to Community Services:** Explain why the youth's needs cannot be met at home/resource care/non-clinical living situation. |
| **Treatment History:** Include services/supports that the youth has received, both past and current. |
| **Previous Out-of-Home (OOH) Settings/Hospitalizations:** Please include any OOH settings the youth has been at, including name of setting, dates, and reason for admission. |
| **Trauma History:** ☐ No ☐ Yes If yes, please describe trauma (i.e., setting such as current family or household, environmental violence, abuse, neglect, or exploitation, etc.). |

**Referral Information** (continued)

**Medical Considerations:** Include allergies, diabetes, asthma, physical limitations, special sensory needs, etc. as well as medical treatment or monitoring required.

☐ None ☐ Other (If other, please explain):

**Risk Behaviors:** Please include historical & current. Explain where applicable.

**At risk for human trafficking:** ☐ No ☐ Yes (If yes, please explain):

**Substance Use:** ☐ No ☐ Yes (If yes, please explain):

**Suicide Risk:** ☐ No ☐ Yes (If yes, please explain):

**Self-Injurious Behaviors:** ☐ No ☐ Yes (If yes, please explain):

**Problematic Sexual Behavior:** ☐ No ☐ Yes (If yes, please explain):

**Fire-Setting:** ☐ No ☐ Yes (If yes, please explain):

**Assault History:** ☐ No ☐ Yes (If yes, please explain):

**Knowledge of gang involvement:** ☐ No ☐ Yes (If yes, please explain):

| **Legal Involvement** |
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| **Legal Challenges:** ☐ No ☐ Yes (If yes, please explain): |
| **Court Order:** ☐ No ☐ Yes (If yes, please explain and attach court order): |
| **Probation involvement:** ☐ No ☐ Yes |
| **Parole involvement:** ☐ No ☐ Yes |

| **Education** (check all that apply) | | |
|---|---|---|
| ☐ In School | ☐ Home Instruction | ☐ Not enrolled in school |
| ☐ Educationally classified | ☐ Not classified | ☐ Has current IEP |
| ☐ Other (Explain): | | |

| **Current DSM 5 Diagnoses** (Refrain from listing codes only) |
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| 1.<br>2.<br>3.<br>4. |
| **Date of Diagnosis(es)**: |
| **Diagnosing Clinician and Credentials**: |
| **Current Prescription Medications:** Specify all medication prescribed to the youth. It is required to provide all of the following: medication name, dosage, frequency, and prescribing practitioner. |
| **Youth Engagement:** 1. What is the youth's understanding of their strengths, needs, and role in receiving treatment services? 2. What is the youth's understanding about the purpose of crisis stabilization services as a short-term stabilization service? *A conversation must be had with the youth to ensure their understanding of crisis stabilization services and willingness to engage as it is a voluntary treatment service.* |

| **Current DSM 5 Diagnoses** (continued) |
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| **Family Engagement:** 1. What is the family's understanding of their strengths, needs, and role in the youth's care? 2. What is the family's understanding about the purpose of crisis stabilization services as a short-term stabilization service? 3. Is the family willing to engage in the youth's treatment, if applicable? *A conversation must be had with the family to ensure their understanding of crisis stabilization services as it is a voluntary treatment service.* |
| **Concurrent Plan:** 1. What is the concurrent plan upon stabilization? 2. Please explain if there are any barriers to achieving the concurrent plan. If applicable, what is the team's plan to overcome such barriers? (Please note, awaiting transition directly from a crisis stabilization treatment service to an available opening at an OOH treatment setting is not a viable concurrent plan as stabilization services are short-term.) |
| **Safety or Soothing Plan:** Is there a safety or soothing plan? If yes, please describe. |

| **Referent** |
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| **By signing this form below, I acknowledge that I have completely reviewed this form to document the most updated information pertaining to this youth and have included the applicable attachments.** |
| **CMO Care Manager**: |
| **CMO Supervisor**: |
| **Clinical Administrator or Designee**: |
| **CP&P Case worker**: |
| **CP&P Supervisor/Casework Supervisor**: |
| **CP&P Team Lead:** |