



Date and Time Received: _____
By Whom: _____
Referring Worker/Agency _____

**Tentative RTC Discharge Date:** \_\_\_\_\_  
 (If applicable)

## WRAPAROUND MARYLAND REFERRAL

**Identified Child:**

Child's Name: \_\_\_\_\_

<b>Race:</b>	<b>D.O.B.</b>	<b>Age:</b>
<b>SS#:</b>	<b>Private Insurance Name:</b>	<b>Ins. #</b>
<b>Medical Assistance</b>	<b>MA #</b>	
<b>Chessie #</b>	<b>Assist #</b>	

**Is the youth committed to and/or in the custody or guardianship of DHR/DSS OR DJS?**

Yes \_\_\_\_\_ No \_\_\_\_\_ Which Agency? \_\_\_\_\_

DJS/DSS Name and Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please provide a copy of the court order.

Parent(s)/Guardian(s): \_\_\_\_\_

Parent(s)/Guardian(s) are:  Biological  Step-Parent  Adoptive Parent  Grandparent  
 Live-in friend/Relative  Foster Parent  Other: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

County: \_\_\_\_\_

Phone Numbers: H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

Race: \_\_\_\_\_

Current Youth Placement Address: \_\_\_\_\_

Contact Person at Placement (Name & Phone No.) \_\_\_\_\_

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abandonment              | <input type="checkbox"/> Housing                    | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> Diagnosed Mental Illness | <input type="checkbox"/> Medical                    | <input type="checkbox"/> Aggression/Assault       |
| <input type="checkbox"/> Financial                | <input type="checkbox"/> Emotional Disability       | <input type="checkbox"/> Suicidal                 |
| <input type="checkbox"/> Drug Abuse               | <input type="checkbox"/> Neglect                    | <input type="checkbox"/> Prostitution             |
| <input type="checkbox"/> Alcohol Abuse            | <input type="checkbox"/> Family Conflict            | <input type="checkbox"/> Runaway                  |
| <input type="checkbox"/> Death of Parent(s)       | <input type="checkbox"/> Legal Issues/Incarceration | <input type="checkbox"/> School Problems          |
| <input type="checkbox"/> Sexual Abuse             | <input type="checkbox"/> Physical Abuse             | <input type="checkbox"/> Behavior Problems        |
| <input type="checkbox"/> Promiscuity              | <input type="checkbox"/> Delinquency                | <input type="checkbox"/> Learning Disability      |

Other: \_\_\_\_\_

Explain indicators: checked

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**Referring Agency:**

Brief History:

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Desired Outcome from Wraparound Participation:

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Current mental health and community services *(list agencies that served this family):*

Service Type	Provider Name and Contact Information	Frequency

*\*Please use additional sheets for other providers.*

Previous mental health services *(list agencies that have served this family):*

Service Type	Provider Name and Contact Information	Frequency

Person Who Conducted Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

DSM IV Diagnosis:

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

GAF Current: \_\_\_\_\_ Highest in Last Year: \_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_

School Placement: \_\_\_\_\_

Contact Information: \_\_\_\_\_

By signing this agreement, I have indicated that I give the referring agency and wraparound staff permission to discuss this referral and to exchange written records as needed.

\_\_\_\_\_  
(Signature of Parent or Primary Caregiver)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Referring Agency\*)

\_\_\_\_\_  
Phone Number for Referring Agency

\_\_\_\_\_  
(Printed name of Referring Agency Representative\*)

\_\_\_\_\_

\_\_\_\_\_  
(Signature of Referring Agency Representative\*)

\_\_\_\_\_  
Date

For Care Coordinator Use	
Date Received:	_____
Initial Contact (must be within 3 days of receipt of referral):	Date: _____ Time: _____
Face to Face scheduled (must be within 7 days of referral):	Date: _____ Time: _____