# Blair County High Fidelity Wraparound Referral Form

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| **Date of Referral:** | | **Referral Agency/System:** | |
| **Contact Person:** | **Contact Phone/Email:** | | **Contact Fax:** |
| **Youth's Name:** | **DOB:** | **SS#** | **Phone:** |
| **Address:** | | **Medical Assistance #:** | |

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|---|---|
| **Mother's Name:**<br>**Address:**<br>**Phone:**<br>**Behavioral health history** ☐ YES ☐ NO ☐ Unknown<br>**Receiving Services:** ☐ YES ☐ NO ☐ Unknown | **Father's Name:**<br>**Address:**<br>**Phone:**<br>**Behavioral health history** ☐ YES ☐ NO ☐ Unknown<br>**Receiving Services:** ☐ YES ☐ NO ☐ Unknown |

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| **Who has primary custody of the youth referred?**<br>**Name:**<br>**Phone:**<br>**Address:** | **Is custodian aware of this referral?**<br>☐ YES ☐ NO |

**Others living in the home (please list name, age and relationship to youth)**

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| **DIAGNOSIS:** | **MEDICATIONS:** | |
| **School District/Building:** | **Grade:** | **IEP:** ☐ YES ☐ NO |

**Reason for referral? (List specific concerns and how High Fidelity Wraparound can help)**

**Please list any current or previous involvement? (within past year)**

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| **CYF** | ☐ YES ☐ NO | **Contact:** | **Phone/email:** |
| **JPO** | ☐ YES ☐ NO | **Contact:** | **Phone/email:** |
| **Mental Health** | ☐ YES ☐ NO | **Contact:** | **Phone/email:** |
| **D&A** | ☐ YES ☐ NO | **Contact:** | **Phone/email:** |
| **Other:** | | **Contact:** | **Phone/email:** |

**Any children in the home at risk for out-of-home placement:** ☐ YES ☐ NO

**Any immediate safety concerns?** ☐ YES ☐ NO **If yes to either question, please explain:**

**Is there a crisis plan in place?** ☐ YES ☐ NO

**Additional pertinent information:**

Please send completed form to Blair HealthChoices, Attention: Brittany Feaster
Send via encrypted email only to: bfeaster@blairhealthchoices.org or Fax: 814-695-5132