

SPECIALIZED SERVICES REQUEST FORM

YOUTH \_\_\_\_\_ JETS # \_\_\_\_\_ DOB \_\_\_\_\_ HOUSING UNIT \_\_\_\_\_

FROM: \_\_\_\_\_ DATE OF REQUEST: \_\_\_\_\_

I. PLEASE INDICATE APPROPRIATE SERVICES:

- PSYCHIATRIC EVALUATION
SUBSTANCE ABUSE TREATMENT
INDIVIDUAL THERAPY
COUNSELING
BEHAVIOR MANAGEMENT
EDUCATIONAL ASSISTANCE
PSYCHOLOGICAL EVALUATION
PRE-RELEASE PROGRAM
GROUP THERAPY
RECREATION THERAPY
OTHER (SPECIFY)
EDUCATIONAL SUPPORT (Specify Curriculum)

II. REASON(S) FOR REFERRAL: (Check all that apply)

- MEDICATION CHECK
ASSESS NEED FOR MEDICATION
FURLOUGH/EARLY RELEASE REQUEST FOR EVALUATION
COURT ORDERED EVALUATION
HALLUCINATIONS
ALTERCATION
DEPRESSION
PREVIOUS PSYCHIATRIC HOSPITALIZATION
ANGER PROBLEMS
SUBSTANCE ABUSE
BEREAVEMENT ISSUES
SLEEP DISTURBANCE
POOR PARTICIPATION IN ACTIVITIES
SUICIDE ATTEMPT WITHIN LAST
SUICIDE ATTEMPT OVER ONE YEAR
SUICIDE GESTURE WITHIN LAST
SUICIDE GESTURE OVER ONE YEAR
CURRENT SUICIDE IDEATION
SUICIDE IDEATION WITHIN LAST
SUICIDE IDEATION OVER ONE YEAR
SELF-MUTILATION HISTORY
CURRENT SELF-MUTILATION
ATTENTION/ACTIVITY IN CLASSROOM
OTHER (Specify)

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Please indicate following:

- Is Youth currently on MHMO?
Has Youth been on MHMO more than seven (7) days?
Has Youth ever been on MHMO?

COMMENTS: \_\_\_\_\_

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III. REFERRED TO:

- PSYCHIATRIST
SOCIAL WORKER
SCHOOL PERSONNEL
SOCIAL SERVICES
PSYCHOLOGIST
RECREATION THERAPIST
PHYSICIAN

IV. REVIEWED AND APPROVED: \_\_\_\_\_

DISAPPROVED: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_
Dorm Manager

DATE: \_\_\_\_\_

V. SERVICE PROVIDER ACTION TAKEN:

\_\_\_\_\_

SIGNATURE: \_\_\_\_\_
Service Provider's Signature

DATE: \_\_\_\_\_

cc: Master Record
Principal