COMUNIDADES LATINAS UNIDAS EN SERVICIO

Date of Referral:

CTSS Skills Training External Referral Form

Client Name:	Date of Birth:
Ethnicity: ☐ Latino ☐ Caucasian ☐ African American ☐ Native American ☐ Asian American ☐ Other _____	
Parent/Guardian Name(s):	
Address: *In-home services may not be available to clients who live more than 30 minutes from a CLUES location	
Phone number:	

Referral Source:	Relationship to Client:
Agency/Organization:	
Address:	
Phone number:	Fax Number or Email:

Is the child currently receiving therapy? ☐ Yes ☐ No

Name of therapist (if not referral source):

Agency: Phone Number:

If the child is receiving therapy, please make sure to include all the current documentation listed below:

- ☐ Diagnostic Assessment
- ☐ Treatment Plan
- ☐ Most recent CASII, SDQ, and/or other standardized instrument
- ☐ Release of Information

Other current social/psychological services:

www.clues.org

797 East Seventh Street
Saint Paul, Minnesota 55106
Tel: (651) 379-4200
Fax: (651) 292-0347

2600 East 25th Street
Minneapolis, Minnesota 55406

Insurance Company:
Primary Policy Holder:
Group Number:
Policy/ ID Number:

What behavioral concerns will CTSS services address?

(Please specify frequency of behaviors and examples under each category selected)

☐ Aggression	☐ Eating/food issues	☐ Social skills
☐ Anger Management	☐ Hygiene	☐ Tantrums
☐ Anxiety-Related Behaviors	☐ Hyperactivity	☐ Other/additional behavioral concerns
☐ Attention	☐ Isolation	
☐ Compulsive behavior	☐ Self-harm/self-injury	

Where are the target behaviors present?

☐ Home ☐ School ☐ Other:
For home-based services, what is the family's availability? (Days of the week, earliest time available, etc…)
For school-based services: Name of school: Grade: Primary school contact:

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Medical necessity language (below) is: *(choose one)*

☐ Included in the DA ☐ Attached below as addendum

CTSS Medical Necessity Language

Based on a review of this client's symptoms and behaviors, it appears that due to their mental health diagnosis/es of , the client is struggling with a delay in development in specific areas relative to their peers. These areas are . CTSS services, which is a combination of therapy and skills work, is medically necessary to rehabilitate this child in these areas of development, and to return the client to a more normal developmental trajectory. Based on the presentation of behaviors in the , services are needed to support the client in this environment, necessitating travel time by the CTSS provider.

Please note that external referrals will be accepted, but not screened without a **release of information, current diagnostic assessment, current treatment plan and most recent CASII, SDQ, and/or any other standardized instrument.

Please fax or email the referral form and documentation requested to:

Email: mhintake@clues.org Fax: 651-292-0347 Attn: Mental Health Intake