Connecticut Department of Children and Families

DMHAS Young Adult Services Program Referral Checklist

DCF-788

12/2021 (Rev)

Referrals that are incomplete will be returned to the Area Office **Date Completed:**

Client's Full Name: **Case LINK#**: *This section completed by RRG Only. (*Explain why in the note section.)* DMHAS Priority: ☐ I / ☐ II* Referral Status: ☐Standard / ☐Prioritize* Case Status: ☐Will remain open / ☐Closing* on ____________	**Included**	**Not Applicable**	**Requested will forward**	**Not Available**	**Document Name and Document Date** **(If included, list the most current one only)**
Legal					
Release of Information (ROI) If client is 18, the client must sign. If the client has a conservator of person, the conservator must sign. If the youth is committed, the SW or SWS must sign.	☐				
Current Clinical Documentation **(Current is within 1 year)**					
Documentation from current Mental Health Provider which includes Mental Health Diagnosis (this should match what is written on the referral form).	☐	☐	☐	☐	
Documentation to support diagnosis (e.g., intake, bio-psychosocial evaluation, etc.)	☐	☐	☐	☐	
Psychological Evaluation from past year	☐	☐	☐	☐	
Neuropsychological Evaluation from past year	☐	☐	☐	☐	
Neurological Evaluation from past year	☐	☐	☐	☐	
Psychiatric Hospitalization records from past year	☐	☐	☐	☐	
Psychosexual Evaluation within past year	☐	☐	☐	☐	
Current Description of Inappropriate Sexual Behavior/Risk	☐	☐	☐	☐	
Fire Setting/Other Risk Assessment within past year	☐	☐	☐	☐	
Current Description of Fire Setting/Other Risk Behavior	☐	☐	☐	☐	
Current Clinical Summaries form Residential Providers	☐	☐	☐	☐	
All available Learning Inventory of Skills Training Assessments (**LIST**)	☐	☐	☐	☐	
Past Clinical Documentation (> 1 Year)					
Documentation from past Mental Health Provider(s) which includes Mental Health Diagnoses	☐	☐	☐	☐	
Past Evaluation(s) (i.e., Psychological, Neurological, Neuropsychological)	☐	☐	☐	☐	
Past Risk Assessments (i.e., Psychosexual, Fire Setting, etc.)	☐	☐	☐	☐	
Past Psychiatric Hospitalization records	☐	☐	☐	☐	
Past Clinical Summaries from Residential Providers	☐	☐	☐	☐	

Client Name: **Case LINK#**:	**Included**	**Not Applicable**	**Requested will forward**	**Not Available**	**Document Name and Date**
Medical					
Documentation of Allergies	☐	☐	☐	☐	
Documentation of significant medical conditions	☐	☐	☐	☐	
List of **current** medications (i.e., client is taking now)	☐	☐	☐	☐	
List of past medications	☐	☐	☐	☐	
Education					
Most recent IEP (**with exit criterion**)	☐	☐	☐	☐	
IQ Scores (If FSIQ is <70, referral should include a DDS denial letter or documentation that indicates DDS is not needed.)	☐	☐	☐	☐	
Other Educational Documents (e.g., Triennial Evaluations inclusive of Occupational Therapy Evals, Speech Evals, etc.)	☐	☐	☐	☐	

Miscellaneous

Describe Additional Document(s) Included:

RRG Notes (Completed by RRG/Clinical Staff Only)

RRG/Clinical Staff Signature

I have reviewed this referral and find that it is appropriate to forward to the Department of Mental Health and Addiction Services for an eligibility determination for the Young Adult Services Program.

Name:	License:	Date: