**North Sound BH-ASO Case Consultation Request**

**Definition**

Case Consultation is a process that occurs ***prior*** to a Children’s Long-Term Inpatient Program (CLIP) application being considered. It allows a youth/family/community team the opportunity to present the current challenges to the consultation committee for review, discussion and possible solutions to help improve treatment and/or recommend other interventions.

**Goal**

The case consultation committee will review submitted information, listen, discuss the current challenges and apply their expertise in the system they represent. The goal is to work in conjunction with youth/family/community team to formulate next steps in treatment and/or other interventions in order to foster recovery and resiliency.

**Members**

The current membership of the case consultation committee are representatives from:

* Mental Health - Behavioral Health Administrative Services Organization (BH-ASO)
* SUD – Behavioral Health Administrative Services Organization (BH-ASO)
* Department of Children, Youth and Family (DCYF)
* Developmental Disabilities Administration (DDA)
* Northwest Educational Service District (NWESD)
* Managed Care Organizations (MCO)

**Recommendations**

1. Feel free to contact the ASO representative listed on this form for discussion prior to submitting
2. Obtain the proper consent from youth 13 years or older prior to submission of this request or any other documentation
3. Please feel free to include the youth’s specific team members (e.g., PO, mental health, psychiatrist, DDA, natural supports, etc.) as dictated by family & community team decision
4. While the case consultation committee supports youth involvement, the committee does not recommend youth under age 16 participate in this type of meeting. The ASO office is not a behavioral health agency and lacks the environmental structure and staff to provide care or interventions a youth may require. For youth 16 and over, the discretion of their ability to participate is left to the family/community team to determine.

**Directions**

Please complete all areas of the form. For areas that do not pertain, indicate that it is not applicable by typing “N/A”. Once the form is completed, fax or mail the form and all requested collateral documentation to:

**North Sound Behavioral Health Administrative Services Organization (North Sound BH-ASO)**

**Attn: Angela Fraser-Powell MA, LMHC, CMHS.**

Fax (360) 416-7013 ***Or*** Mail To:

2021 E. College Way, Suite 101

Mount Vernon, WA 98273

Once the information is received, the ASO will work with you to set up a meeting using the contact information you provided.

Case Consultation Request Information

Form Completed By

|  |  |
| --- | --- |
| *Name:* |  |
| *Agency (if applicable):* |  |
| *Date Completed:* |  |

Demographic Information

|  |  |
| --- | --- |
| *Youth’s Name:* |  |
| *Youth’s Preferred or Nickname:* |  |
| *Youth’s Address (incl. city, zip code)* |  |
| *Youth’s DOB:* |  |
| *Youth’s Age:* |  |
| *Youth’s Gender:* | [ ]  Male [ ]  Female [ ]  Transgender |

|  |  |
| --- | --- |
| *Is Youth Adopted?* | [ ]  Yes [ ]  No If yes, was it a WA State Adoption? [ ]  Yes [ ]  No |
| *Does family receive adoption support?* | [ ]  Yes [ ]  No |

|  |  |
| --- | --- |
| *Parent/Legal Guardian Name:* |  |
| *Contact Number:* |  |
| *Address:* |  |

|  |  |
| --- | --- |
| *Parent/Legal Guardian Name:* |  |
| *Contact Number:* |  |
| *Address:* |  |

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| --- | --- |
| *Youth’s Medical Insurance Carrier:* |  |
| *Does Youth have SSI?* | [ ]  Yes [ ]  No |
| *If no, has SSI been applied for?* | [ ]  Yes [ ]  No |
| *If SSI for the youth was applied for and denied, did you file an appeal?* | [ ]  Yes [ ]  No |

Case Information

*Please describe the family constellation (include ages of youth living in the home, non-blood relations, etc.)*

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*What is the youth, family and community team’s expectations / hopes of the North Sound Case Consultation Committee meeting? (be specific)*

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*Please describe the challenges the youth, family and community team are currently experiencing that have led to the referral? (be specific)*

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*Please describe the strengths and resources of the youth and family? (be specific)*

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*What are the specific questions the youth, family and the community team would like to ask the North Sound Case Consultation Committee?*

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*What other pertinent information does the North Sound Consultation Committee need to know about this referral?*

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NATURAL SUPPORTS

*Please list all persons (family, friends, church, etc.) who provide natural support to the youth and family.*

|  |  |
| --- | --- |
| *Name and Role:* |  |
| *Name and Role:* |  |
| *Name and Role:* |  |
| *Name and Role:* |  |
| *Name and Role:* |  |
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| *Name and Role:* |  |
| *Name and Role:* |  |
| *Name and Role:* |  |

MENTAL HEALTH INFORMATION

|  |  |
| --- | --- |
| *Outpatient Mental Health Provider Agency (current):*  |  |
| *Outpatient Therapist Name:*  |  |
| *Phone Number:*  |  |
| *Outpatient Prescriber Name:*  |  |
| *Phone Number:*  |  |

|  |  |
| --- | --- |
| *Current Full-Scale IQ (if applicable)*  |  |
| *Date IQ was obtained (if applicable)*  |  |
| *Where and by whom was the most recent IQ test administered?* |  |

***Current Medications***

|  |  |  |  |
| --- | --- | --- | --- |
| *Medication:* |  | *Dosage:* |  |
| *Medication:* |  | *Dosage:* |  |
| *Medication:* |  | *Dosage:* |  |
| *Medication:* |  | *Dosage:* |  |
| *Medication:* |  | *Dosage:* |  |
| *Medication:* |  | *Dosage:* |  |

***Current Working Psychiatric Diagnosis***

|  |  |  |  |
| --- | --- | --- | --- |
| *Diagnosis:* |  | *Diagnosis:* |  |
| *Diagnosis:* |  | *Diagnosis:* |  |
| *Diagnosis:* |  | *Diagnosis:* |  |

 ***Outpatient Treatment History***

|  |  |  |  |
| --- | --- | --- | --- |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |

***Inpatient Treatment History***

|  |  |  |  |
| --- | --- | --- | --- |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |
| *Provider:* |  | *Start/End Dates:* |  |

***Psychological Assessments Administered***

|  |  |  |  |
| --- | --- | --- | --- |
| *Provider:* |  | *Date:* |  |
| *Provider:* |  | *Date:* |  |
| *Provider:* |  | *Date:* |  |
| *Provider:* |  | *Date:* |  |
| *Provider:* |  | *Date:* |  |
| *Provider:* |  | *Date:* |  |

*What were the reasons for the referral to outpatient therapy and when did it begin?*

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*Please describe past and present treatment interventions that* ***have been*** *effective.*

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*Please describe past and present treatment interventions that have* ***not been*** *effective.*

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SUBSTANCE ABUSE INFORMATION

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| *Is the youth currently receiving treatment for Substance Abuse?*  | [ ]  Yes [ ]  No |
| *If yes, please describe the current treatment progress.* |

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| *Does the youth have a history of Substance Abuse treatment?* | [ ]  Yes [ ]  No |
| *If yes, please describe the treatment history and outcomes of treatment.* |

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| *If there is no current or historical treatment, is there suspected use at this time?*  | [ ]  Yes [ ]  No |
| *If yes, please describe the concerns.* |

MEDICAL

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| --- | --- |
| *Current Medical Provider:*  |  |
| *Date of last physical:*  |  |
| *Date of last medical appointment:*  |  |
| *Date of last well child check:*  |  |

*Current medical concerns (if any).*

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DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

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| --- | --- |
| *Does the youth have or are concerns the youth may have a developmental disability?* | [ ]  Yes [ ]  No |

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| --- | --- |
| *If yes, does the youth have services with DDA?* | [ ]  Yes [ ]  No |
| *Social Worker Name:* |  |
| *Social Worker Phone Number:* |  |

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| *If no, have services through DDA been applied for?*  | [ ]  Yes [ ]  No |
| *If services have been applied for but youth was denied, have you filed an appeal?* | [ ]  Yes [ ]  No |

*Current DDA Services*

|  |  |  |  |
| --- | --- | --- | --- |
| *Service:* |  | *Date:* |  |
| *Service:* |  | *Date:* |  |
| *Service:* |  | *Date:* |  |
| *Service:* |  | *Date:* |  |
| *Service:* |  | *Date:* |  |
| *Service:* |  | *Date:* |  |

DEPARTMENT OF CHILDREN, YOUTH & FAMILIES (DCYF)

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| *Current DCYF involvement (includes Tribal if applicable)?*  | [ ]  Yes [ ]  No |
| *Case Manager Name:* |  |
| *Case Manager Phone Number:* |  |

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| *Youth’s DCYF Legal Status:*  |  |
| *CASA / GAL Name (if applicable):*  |  |
| *CASA / GAL Phone Number:*  |  |

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| --- | --- |
| *Is there historical involvement with DCYF?*  | [ ]  Yes [ ]  No |
| *If yes, please briefly describe:* |  |

SCHOOL

|  |  |
| --- | --- |
| *Currently enrolled in school?*  | [ ]  Yes [ ]  No |
| *Current School:* |  |
| *Current School District:*  |  |

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| *Does the youth have a 504 Plan?*  | [ ]  Yes [ ]  No |
| *If yes, please state the reasons for the 504 Plan:* |  |

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| --- | --- |
| *Does the youth have an IEP?*  | [ ]  Yes [ ]  No |
| *If yes, please state the reasons for the IEP:* |  |

*Current School Supports (if applicable)*

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| --- | --- | --- | --- |
| *Support:* |  | *Support:* |  |
| *Support:* |  | *Support:* |  |
| *Support:* |  | *Support:* |  |

*Please describe areas of need as well as strengths the youth has with school.*

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LEGAL

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| *Is the youth currently involved with JJRA?*  | [ ]  Yes [ ]  No |
| *Parole Officer Name:*  |  |

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| --- | --- |
| *If yes, is the youth currently involved with Juvenile Probation?*  | [ ]  Yes [ ]  No |
| *Probation Counselor/Officer Name:*  |  |

*If there is no current involvement, has the youth had a history of legal involvement? (briefly describe)*

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| *Is there a current CHINS in place?*  | [ ]  Yes [ ]  No |
| *Is there a current At-Risk Youth (ARY) in place?*  | [ ]  Yes [ ]  No |
| *ARY Case Manager Name:*  |  |

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| *Is the youth currently involved in a Truancy Board?*  | [ ]  Yes [ ]  No |
| *If yes, please describe the involvement with the Truancy Board:* |  |