St. Clair County Community Mental Health

Challenging Behavior Referral

Name: _____ Case #: _____ Date of Referral: _____

Does this individual have a guardian? ☐ Yes ☐ No Is this individual linked with clinical services? ☐ Yes ☐ No

Age: _____ Program: _____ Clinician Name: _____

Guardian Name: _____ Guardian Phone #: _____

Diagnosis: _____

Living Situation: ☐ With Family ☐ Independently ☐ House of Your Own (HOYO) ☐ Residential Setting

Group Home Name (if applicable): _____ Phone #: _____

Address: _____

Caregiver/Contact Name: _____ Phone #: _____

The referred individual is: (check all that apply)

☐ Verbal ☐ Non-Verbal ☐ Uses Sign Language ☐ Uses Visual Supports

☐ Is in good health ☐ Has a seizure disorder ☐ Has other medical factors

Medications:

_____

_____

_____

Reason for Referral:

☐ Consultation Only ☐ Clinical Assessment ☐ Behavioral Assessment*

Explain: ***If Behavioral Assessment is being requested, provide justification for skipping Clinical Assessment**

_____

_____

_____

_____

_____ _____ _____

Supervisor Signature Print Name Date

Please submit completed referral to: Ryan Gladfelter & Robert Shafran

Once referral is reviewed, the form will then be forwarded to the Scanning Department.

☐ **Referral Received & Reviewed**