

## Referral Form - Clinical Case Management and Placement Services for Residential Treatment

Referral Date:	Student Name:	
Date of Birth:	Home Address:	
SpEd Eligibility:	District + Current School + Grade:	
IEP Team Members	Name, Phone, Email	
☐ Parent/Guardian/Caregiver		
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☐ District Contact		
☐ Case Manager/Content Specialist		
☐ School-Based Counselor/RTC Therapist		
Reasons for Referral (District concerns including	high risk behaviors and safety issues)	
□ Student is surrently placed at a Desidenti	al Treatment Center (PTC) Name of PTC	Admirsion Date:
☐ Student is currently placed at a Residentia	al Treatment Center (RTC). Name of RTC:	Admission Date:
Services Requested		
on caregiver and school staff interviews, as provide clinical recommendations to suppo  Clinical Case Management On behalf of the school district, Clinical Case environment, and educational goals. CCMs	dential treatment centers meet a student's un well as record review. Additionally, Placement it districts in making an appropriate offer of Formal Managers (CCMs) visit students placed at an participate in IEPs and regularly meet with treaters.	RTC on a quarterly basis to monitor treatment, atment team members to gather current
information regarding student progress. In addition to addressing caregiver and/or district concerns, CCMs' clinical oversight helps to ensure appropriate fit, reasonable length of stay, and a timelier return home for students.		
Preferred start date of services:		
Please attach the following and indicate	e all that are available:	
□ SEIS access	☐ Current IEP with sign	ed consent for services listed above
☐ Psychoeducational/Psychological/ERMHS	assessment(s)	
$\hfill \square$ Authorization to exchange confidential in	nformation with school district	
	Send form to: referrals@embrace-mh	.org

**Questions? Contact:** 

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