**C.A.R.E. Program Referral Form**

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| Date of referral: |  | Referral source: | | | J.D. McCarty  DHS  DDS Other: | |
| ***\*\* Email completed form to care@jdmc.ok.gov\*\**** | | | | | | |
| Name of person completing the referral: | | |  | | | |
| Primary phone: |  | | Email: | | |  |
| Have you notified the caregiver of this referral? | | | | Yes  No | | |

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| **PARENT / GUARDIAN CONTACT INFORMATION:** | | | | | | | |
| **Guardian’s name:** | |  | | | **Relationship:** | |  |
| **Primary phone:** | |  | **Secondary phone:** |  | | **Email:** |  |
| **Address:** |  | | | | | | |

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| **Name of individual:** | | |  | | **Date of birth:** | |  |
| **Address:** |  | | | | | **County:** |  |
| **Gender:** |  | | | | | **SSN:** |  |
| **Insurance?** | | Unknown  SoonerCare/Medicaid  Medicare  TEFRA  Private: | | | | | |
| **Verbal?** | | Yes  No  Uses communication device | | | | | |
| **DIAGNOSES:** | | | | | | | |
| **Current Psych Evaluation on file?**   Yes  No  Unknown | | | | | | | |
| **Diagnosis:** | |  | | Confirmed with testing  Perceived  Ruled out | | | |
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| **OKDHS CONTACT INFORMATION:** | | | | | | | | | |
| **CWS name:** |  | | | | | | **Case status:** | |  |
| **Primary phone:** | |  | | **Secondary phone:** |  | | | **Email:** |  |
| **KK/ Referral Number:** | | |  | | | | | | |
| **CWS supervisor:** | | |  | | | | | | |
| **Primary phone:** | | |  | | **Email:** |  | | | |

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| **DDS CONTACT INFORMATION:** | | | | | | | | | |
| **DDS name:** |  | | | | | | **Case status:** | |  |
| **Primary phone:** | |  | | **Secondary phone:** |  | | | **Email:** |  |
| **DDS supervisor:** | | |  | | | | | | |
| **Primary phone:** | | |  | | **Email:** |  | | | |

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| **REASON FOR REFRRAL** (*Please list as much information as possible*) |
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| **SOCIAL INFORMATION:** | | | | | | |
| **Household makeup** *(list who resides in the home and their relationship to the child/young adult):* | |  | | | | |
| **Do any other members of the household have a diagnosed or perceived intellectual or developmental disability?** | Yes  No | | **If Yes, explain:** | | |  |
| **Is there a risk for placement disruption?** | Yes  No | | **Explain, listing timeframe if possible:** | | |  |
| **Is there a risk for DHS involvement?** | Yes  No | | **If Yes, Explain:** | |  | |
| **Is the client currently receiving any resources/therapies/services?** | Yes  No | | **If Yes, explain:** | |  | |
| **List any specific needs the caregiver has identified:** | | | |  | | |

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| **EDUCATION:** | | |
| **Name of school client attends:** |  | |
| **Does the client currently have an IEP plan on file?** | | Yes  No  Unknown |
| **Additional Information:** | |  |

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| **SPECIAL CONSIDERATIONS:** |
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