Community Wraparound Teaming (CWT)
Referral Form

Referent/Agency:	**Referent's Phone Number:**
Date Referral Started:	
The purpose of this CWT meeting is: ☐ Consultation ☐ Request for Children's Long-Term In-Patient (CLIP) services	
1. Referred Youth's Information	
Name:	Date of Birth:
Will the youth be attending the meeting? ☐ YES ☐ NO	
My Primary Language:	My Secondary Language:
I need an interpreter. ☐ YES ☐ NO	I can read English: ☐ YES ☐ NO
2. Parent or Caregiver Information	
Name:	Relationship to Youth:
Name:	Relationship to Youth:
Address of Primary Caregiver(s):	Phone 1: Phone 2: Best time to call: May we leave VM? ☐ YES ☐ NO **Email:**
My Primary Language:	My Secondary Language:
I need an interpreter. ☐ YES ☐ NO	I can read English: ☐ YES ☐ NO
I need an interpreter. ☐ YES ☐ NO	I can read English: ☐ YES ☐ NO

3. Current Location of Youth and for How Long?

Is Child/Youth Currently in a Facility Outside of the Home?

☐ YES ☐ NO If Yes, Provide the Facility Name: Start Date:

Select All that Apply Below:

☐	**Boarded in an Emergency Department**	☐	In-Patient Hospital on Medical Floor
☐	In-Patient Psychiatric Hospital	☐	JRA Facility
☐	County Juvenile Detention	☐	Group Foster Care
☐	CLIP Facility	☐	Shelter/Homeless
☐	DCYF Placement	☐	Other:

4. Ongoing Living Situation of Youth?

(Select All that Apply)

☐	One Parent Family	☐	Adoptive Family
☐	Two-Parent Family	☐	Grandparent(s)
☐	Other Relative	☐	Family Foster Care
☐	Other:		

5. Is there any assistance/support that your family needs in addition to intensive psychiatric supports addressed on the second document? Please describe.

6. Please identify other individuals that the <u>family will be inviting</u> to the CWT meeting

☐	Mental Health	Agency/Contact:
☐	Child Welfare	Agency/Contact:
☐	Substance Treatment	Agency/Contact:
☐	Developmental Disabilities Administration	Contact:
☐	Juvenile Rehabilitation	Site/Contact:
☐	Parole	Contact:
☐	County Detention	Contact:
☐	Probation	Contact:
☐	Education	School/Contact:
☐	Tribal System	Tribe/ Contact:
☐	Economic Assistance (CSO)	Contact:
☐	Family/Natural Supports	Contact:
☐	Other	Contact:

Please send the referral to TMBH-ASO via email at cwt.referrals@tmbho.org or fax 360-489-1435
The referent will be contacted to schedule the CWT meeting.

Community Wraparound Teaming
Authorization for Release and Exchange of Information

Name _____ Date of Birth _____

(NOTE: This form must be completed before the clients sign it.)

This document authorizes the release/exchange of the information identified below, between the Thurston and Mason County Community Wraparound Teaming (CWT) members for the purpose of identifying additional service and resources that may benefit the family. This release authorizes the designated person(s)/agency(ies) listed below to release/exchange information and reports with each other as needed to identify individual and family service needs and to develop and share a list of potential resources with the family and CWT members, as needed. We will not disclose protected health information to a third party except when statutorily required to do so.

Note: The individuals/agencies in bold below regularly participate in CWT to help families connect to appropriate services/resources. If you are comfortable with having all CWT members participate in the consultation, check the "I authorize all" box instead of checking each individual bolded box. However, if there are specific persons/agencies that you prefer not to participate, you must check the individual boxes of those that you want at the meeting and leave the other boxes blank.

You are also welcome to add family members, natural supports, medical providers, and others to this release, if you plan to have them participate.

☐ **I authorize all CWT members to release/exchange information and reports for the purpose of the CWT meeting.**

☐ Families/Natural Supports: _____
☐ Medical Provider: _____
☐ **Public School Districts**
☐ **Family Education and Support Services**
☐ **Behavioral Health Resources**
☐ **Catholic Community Services**
☐ **Community Youth Services**
☐ **Consejo Counseling**
☐ **ESD 113 – True North**
☐ **SeaMar**
☐ **Thurston or Mason County Juvenile Probation/Court**
☐ **Department of Children, Youth, and Families**
☐ **Developmental Disabilities Administration**
☐ **Juvenile Rehabilitation Administration**
☐ **Thurston Mason Behavioral Health - ASO**
☐ **WA Behavioral Health Managed Care Organizations**
☐ Other: _____

To exchange ALL information except the following:

☐ CWT Referral Document/Info
☐ Verbal Exchange of Information
☐ Educational Reports
☐ Verbal Exchange of information
☐ Medical Records
☐ Mental Health Records
Psychological Records/Reports
Legal/Court Records
JRA Records
☐ Psychiatric Records/Reports
☐ Drug & Alcohol
☐ Child Welfare Records
☐ Communicable Disease
☐ Other: _____
☐ Other: _____

Alcohol /Drug, Mental Health, and Medical Records may include all aspects of diagnosis, treatment, and prognosis. Educational records indicate both behavioral and progress records.

This authorization is good for one (1) year from date of signature.
I can cancel this authorization in writing at any time prior to the specified expiration, but I understand that the cancellation will not affect my information that was already released before the cancellation. I will let a CWT member know if I want to cancel my authorization. I understand that information about my case is confidential and protected by state and federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so. I understand that information that has been released by an agency is no longer protected by that agency and may be subject to re-disclosure by the recipient, even though further disclosure of this information is prohibited unless permitted by the written authorization of the client, or their parent, guardian, or personal representative.

_____ _____ _____ _____
Signature of Client Date Signature of Guardian or Personal Representative Date

_____ _____ _____ _____
Signature of Witness Date Description of Representative's Authority to act for the Client Date

To those receiving information under this authorization: The information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains, unless authorized by other laws.