Subacute Crisis Stabilization Program (SACS) Referral Form

Please email referral form to sacsreferrals@thevillage.org

The SACS program serves youth ages 5-18 years of age who are experiencing a behavioral health crisis, requiring more than 24 hours for full stabilization and no more than a 14 day stay. Youth will be assessed daily for appropriateness to return to home/school/community.

Consideration for admission could include the following: high risk of hospitalization/re-hospitalization or emergency department use; high likely of continued substance abuse, symptoms are significantly interfering with functioning in the home/community; behaviors have recently escalated; harm to self or other but can likely be prevented through appropriate supervision; youth cannot be fully stabilized without 24-hour observation and cannot be safety maintained in the home or in a lower/intermediate level of care; youth is not acutely dangerous to self or others, not gravely disabled and not a high risk of running away.

REFERRAL SOURCE

Referring Agency: ____

Level of Care: ☐ In-patient ☐ Emergency Room ☐ Other

Contact person: ____________________

Phone number: _________________ Email: _______________________

DEMOGRAPHICS

Youth name/Preferred Pronouns: ____

Date of Birth: _____________________ Age: ____________

Gender: ________________ Preferred Language(s): _________________________

Ethnicity: ☐ Asian American ☐ Hispanic/Latino ☐ Black ☐ White

☐ Native American ☐ Pacific Islander ☐ Other: ____________________________

PARENT/CAREGIVER/LEGAL GUARDIAN

Legal Guardian: ___________________________ Relationship: ________________

Phone: ____________________ Email: ________________________________

Address: ____

Preferred Language: _______________________

Primary Caregiver: _________________________ Relationship: ________________

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Phone: ______________________ Email: ____________________________________

Address: ____

Primary Language: ____

DCF INVOLVEMENT

- ☐ Not DCF involved
- ☐ Not DCF-Probation with Placement
- ☐ Voluntary Services Program
- ☐ Termination of Parental Rights
- ☐ Child Protective Services- In home
- ☐ Child Protective Services- out of the home
- ☐ Family Assessment Response
- ☐ Not DCF- Probation-in home or Parole
- ☐ Not DCF- Other Court Involved
- ☐ Probate

DCF Case Worker: ____________________________ Phone: ____________________

DCF Supervisor: ______________________________ Phone: ____________________

Case ID Link #: ________________________________

When did DCF get involved with the family? ____________________________________

Why? ____

REASON FOR REFERRAL: (Presenting problem, impact of youth's behavior on family, family dynamics, how can family benefit from services)

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PRESENTING CONCERNS:

Please indicate behaviors that the youth demonstrates on the chart below.

Behavior	Current	History	Explanation
Self-Injury			
Aggression toward others			
Property Destruction			
Hallucinations/Delusions			
Suicidal Ideation			
Homicidal Ideation			
Sexualized Behaviors			
Stealing			
Lying			
Temper Tantrums			
Depression			
Anxiety			
Running Away			
Child Trafficking			
Truancy			
Substance Abuse			
Cognitive Limitations			
Developmental Delays			
Enuresis/Encopresis			
Other			

TRAUMA HISTORY

Has the youth been exposed to any of the following traumatic experiences?

☐ Physical Abuse ☐ Witness to Domestic Violence ☐ Community Violence

☐ Sexual Abuse ☐ Significant Loss ☐ Serious Accident/Injury

☐ Neglect ☐ Other: ___________________

PRIOR HOSPITALIZATIONS

Dates	Facility

DIAGNOSES

Diagnosis	Code

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MEDICATIONS (prescribed, over the counter, PRN's)

Name of medication	Dosage	Time	Route

CURRENT PROVIDERS

Primary Care Physician: _______________________ Phone: _________________________
Address: ____________________________________
Date of last physical examination: ______________

Treatment Provider/Agency: ___________________ Phone: _________________________
Address: _____________________________________
Type of treatment: ____________________________

Prescribing Medical Provider: __________________ Phone: _________________________
Address: ____________________________________

Other: _______________________________________ Phone: _________________________
Address: ____________________________________

Local Pharmacy: ___________________________ Phone: __________________________
Address: ___________________________________

INSURANCE

Insurance Company Name: ____________________________

Subscriber: ______________________ Policy #: ____________________________

ID #: ____________________________

*The Subacute program is not a billable service however insurance information is obtained for prescription use at our pharmacy.

CHILDHOOD ILLNESS:

Illness	Current	History	Explanation
Problems with feeding or eating			

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Sleep apnea			
Irregular heartbeat or heart murmur			
Asthma or other breathing problems			
Diarrhea			
Constipation			
Nausea or vomiting			
Kidney or bladder problems such as frequent UTIs			
Seizures			
Frequent headaches			
Diabetes			
Anemia or sickle cell disease			
Cancer			
Scoliosis or other problem with back or spine			
Other			

Any known allergies? (food, medication, environment)? Y/N
(If yes, please list) ____

Does your child need any accommodation for daily functioning (wheelchair, visual or hearing devices)? Y/N
(If yes, please list) ____

Referral from Hospital : Has the child had a COVID test within the last 72hours? Please fax or email results. Vaccination status?

Referral from Home: Testing will be done upon admission.

EDUCATION INFORMATION

School name: ______________________________________Phone: ______________________

Address: ____ Grade: ______________________

Special Education: ☐ Yes ☐ No 504 Plan: ☐ Yes ☐ No

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IEP Classification: ____

School Contact: _____________________________ Phone: __________________________

Extracurricular Program: ______________________ Phone: ___________________________

It is not recommended that the youth attends school while participating in our program but, if chosen to attend, the family/caregiver understands they must provide all transportation.

- ❑ Yes, the child will attend school and transportation arrangements will be made.
- ❑ No, the child will not attend school.

If yes, please provide transportation information below:

Transportation Company: _______________________Phone: ______________________

Transportation Contact: ________________________Email: _______________________

Pick-up time: ___________________ Drop-off time: _______________________

DISCHARGE PLAN
(pending referrals, treatment plan for time of discharge, discharge residence)

YOUTH & FAMILY INVOLVEMENT

If both the youth and family agree to willingly participate in the SACS program, the staff will work with the youth/family to develop a treatment plan following the intake assessments and diagnostic evaluation. Treatment will be tailored to the needs of the youth and support maintaining their stabilization and preparing them to return to their home environment, school, and community with the necessary resources to be successful. Family involvement will include family sessions, daily check-ins, and onsite visits.

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Please check the following:

☐ The family was informed of their role in child’s treatment.
☐ The youth agrees with placement
☐ The family agrees with placement.

By initialing, the referral source is indicating that this information was shared with the youth and family and all parties agree with the placement. ___________________ (initial here)

______________________________________ ________________________________

Signature of Referral Source **Date**

*Revised April 2024