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| **NM High-Fidelity Wraparound Referral Form** |

**Form Must be Completed in Full**

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| **Referral Source** |
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| **Referring Agency** |  |  |  |  | **Date:** |  |
|  |  |  |  |  |  |  |
| **Referring Person** |  |  | **Phone:**  |  | **Email:** |  |
| **Is the Referred person** **involved with CYFD?** |  **Yes** [ ]  **No** [ ]  | **Is CYFD the Legal Guardian**? | **Yes** [ ]  **No** [ ]  | **Is the Legal Guardian aware of this Referral?** | **Yes** [ ]  **No** [ ]  |

 (**Name the CYFD legal guardian on Pg. 3-Agency/System Involvement)**

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| **Information on Referred Individual**  |
|  |
| **First Name** |  |  | **Last Name**  |  |  |
| **Preferred Name?** |  |  | **Sex** |  Male [ ]  Female [ ]  Other [ ]  |
| **DOB** |  | **AGE**  |  | **Self-Identified Ethnicity** |  |  |
|  |  |  |  |  |  |  |
| **Individual’s First Language?** |   | **Language most comfortable communicating in?** |  |  |
|  |  |  |  |  |  |  |
| **Does the Referral live at home?**  |  **Yes** [ ]  **No** [ ]  | **If “No” where does individual Reside?** |  |
| **Current Address** |  | **City** |  | **State** |  |  **Zip** |  |  |
| **Best Contact Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **What MCO provider is individual covered under? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
|  |  |  |  |  |  |  |
| **Caregiver’s Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Relation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Contact Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Family/Caregiver/Support Information**  |

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| **If CYFD is the Legal Guardian are there contact restrictions with family members?** |  **Yes** [ ]  **No** [ ]  |  |
| **1-Parent’s Name** |  | **Best Phone Number** |  | **Can this # Receive Texts?**  **Yes** [ ]  **No** [ ]  |
|  |  |  |  |  |
|  **Language most comfortable communicating in?** |  | **Interpretation Servs. Needed?** |  **Yes** [ ]  **No** [ ]  |
|  |  |  |  |  |
| **Current Address** |  | **City** |  | **State** |  |  **Zip** |  |  |
| **2-Parent’s Name** |  | **Best Phone Number** |  | **Can this # Receive Texts?**  **Yes** [ ]  **No** [ ]  |
|  |  |  |  |  |  |
| **Language most comfortable communicating in?** |  | **Interpretation Servs. Needed?** |  **Yes** [ ]  **No** [ ]  |
|  |  |  |  |  |  |
| **Current Address** |  | **City** |  | **State** |  |  **Zip** |  |  |
|  |  |  |  |  |  |  |  |
|  **Is Parent 1 a Legal Guardian?** |  **Yes** [ ]  **No** [ ]  |  **Is Parent 2 a Legal Guardian?** |  **Yes** [ ]  **No** [ ]  |
|  |  |  |  |  |  |  |  |
| **Please list those currently involved with the referred person** **(Family, Attorneys, MCO Care Coordinator, CASAs, Treatment Provider, School Staff, etc.)** |
| **Name****Name** |  | **Relation** |  |  | **Phone #****Phone #** |  |  |
|  | **Relation** |  |  |
|  |  |  |  |  |  |
| **Name****Name** |  | **Relation****Relation** |  |  | **Phone #****Phone #** |  |  |
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| **Name****Name** |  | **Relation****Relation** |  |  | **Phone #****Phone #** |  |  |
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|  |  |  |  |  |  |
| **Name****Name** |  | **Relation****Relation** |  |  | **Phone #****Phone #** |  |  |
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| **Agency/System Involvement** |

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| **Is Referred involved with CYFD?** |  | **Yes** [ ]  **No** [ ]  | **If “Yes” Which Service** |  |  **PS** [ ]  **JJS** [ ]  **Transition** [ ]  **CBHC** [ ]  |
|  |
| **Name of CYFD Worker (PS/JPO/BHS)** |  | **County** |  | **Contact Number** |  |  |
|  |
| **Name of CYFD Worker (PS/JPO/BHS)** |  | **County** |  | **Contact Number** |  |  |
|  |
| **Check all the Referred individual is involved with** |  **BH Provider** [ ]  **School/Spec. Ed.** [ ]  **Adult/Juvenile Court** [ ]  **Other** [ ]  |
|  |
| **Has the Referral been diagnosed with an SED or SMI diagnosis? Yes** [ ]  **No** [ ]  |
|  |
| **History of Services/Intervention-Newest to Oldest (For More Space Please use the Reverse Side)** |
|  |
| **Name of Provider** | **Contact Number/Person** | **Service/Type of Support** | **Approximate Dates of Service** |  |
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|  | **(Use the back of this sheet if you need additional space)** |  |

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| **Behavioral Health** |

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| **Referral’s Mental Health Diagnosis** | **Date of Diagnosis** | **Medication** |
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|  | **Please list concerning and at risk behavior** |  |
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| **Education** |

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| **Is referred person enrolled in school or employed?** | **Yes** [ ]  **No** [ ]  |  | **If in school, what** **grade level?** |  | **If in school, does individual attend** **If employed # of jobs in the last 12 months**  | **Yes** [ ]  **No** [ ]  |  |
| **Please list education History-Newest to Oldest (Use Reverse for Additional Space)** |
| **School** |  | **Dates Attended** |  | **Contact Person** |  |  **Contact Phone** |  |
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