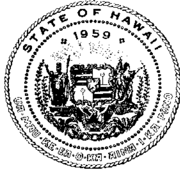

STATE OF HAWAII
DEPARTMENT OF HEALTH
CHILD AND ADOLESCENT MENTAL HEALTH DIVISION
3627 KILAUEA AVE RM 101 HONOLULU HAWAII 96816

SEBD REFERRAL FORM

SUPPORT FOR EMOTIONAL and BEHAVIORAL DEVELOPMENT (SEBD)

INSTRUCTION: Complete Part 1 and fax it to 733-8375, with a cover page, or to the nearest CAMHD Family Guidance Center. For questions, call (808) 733-9815.

PART 1. (TO BE COMPLETED BY THE REFERRAL SOURCE) Date:

CLIENT INFORMATION			
Client Name: Last / First / MI			Gender: ☐ Male ☐ Female
DOB:	SSN:	School attending:	
HAWI ID:	Medicaid: ☐ AlohaCare ☐ Kaiser ☐ FFS ☐ HMSA ☐ Summerlin		Effective Date:
Parent/Legal Guardian:			Phone No:
Mailing Address:			
Youth's address (if different from Parent/Guardian):			How Long:

I hereby consent to the evaluation of my child for the purpose of determining SEBD eligibility and agree that CAMHD may obtain information about my child with the understanding that it cannot be disclosed to others without my further approval, unless permitted by Federal or State law. I also understand that this consent expires in one year.

Parent /Legal Guardian Signature: ______________________ Date: __________

REFERRAL SOURCE INFORMATION	
Referral Submission Date:	Referral Type: ☐ Initial ☐ Reconsideration
Referring Agency/Organization & Unit:	
Referring Person's Name/Phone/Fax:	

I hereby certify that the information I have provided is accurate to best of my knowledge and I recommend the above client for SEBD status consideration.

Referring Person's Signature: ______________________ Date: __________

If DHS has custody of youth, is it permanent custody? ☐ Yes ☐ No

DSM-IV DX CODE	Primary	Secondary
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		
Diagnosis Date:	Diagnosed By:	

Client Name: ______________________________ CR# ____________

CAFAS (within last 2 weeks)	Scores	**CASII (CALOCUS)**	Scores
Work Role Performance – School	_____	Risk of Harm	_____
Role Performance – Home	_____	Functional Status	_____
Role Performance – Community	_____	Co-morbidity	_____
Behavior Toward Others	_____	Recovery Environmental Stressors	_____
Moods	_____	Recovery Environmental Support	_____
Self-Harm	_____	Resiliency & Treatment History	_____
Substance Use	_____	Youth or Parent (record higher score)	
Thinking	_____	Acceptance / Engagement	_____
CAFAS Total	_____	**CASII Total**	_____
By: Date:		By: Date:	

Previous Intervention Strategies Utilized

- ☐ Individual Therapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Psychotropic Medications
- ☐ Intensive In-Home
- ☐ Functional Family Therapy
- ☐ Multisystemic Therapy
- ☐ Therapeutic Foster Home
- ☐ Multidimensional Therapeutic Foster Care
- ☐ Therapeutic Group Home
- ☐ Community Based Residential
- ☐ Hospital Based Residential
- ☐ Acute

Other Evidence Based Services:

History of Medication Trials (Start with current medication. If insufficient space, continue on separate sheet.)

Medication Name	Strength	Freq	Start Date	End Date	Managing Physician	If Discontinued, Specify Reason

PART 2. (TO BE COMPLETED BY THE FAMILY GUIDANCE CENTER)

FGC/Office:	CR#:	Current Registration Date:
Mental Health Eligibility:	BHP Enrolled: ☐ Yes ☐ No	

I have reviewed this referral and recommended the following status:

☐ *Yes* ☐ *Provisional* ☐ *No* ☐ *Presumptive Eligibility – No MHA Attached*

Clinical Director Signature: ______________________________ Date: ____________

PART 3. (TO BE COMPLETED BY THE CAMHD MEDICAL DIRECTOR)

SEBD Begin Date:	Next Review Date:

SEBD Determination: ☐ Yes ☐ Provisional
☐ No ☐ Presumptive Eligibility *two months* – Due date for MHA**:**

Comments: ☐ Criteria Met ☐ Criteria Not Met ☐ Other (see below)
☐ More information needed – Resubmit by: ____________________

Medical Director Signature: ______________________________