

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 safely 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: _____

Phone: _____ Email: _____

Address: _____

Primary Language: _____

DCF INVOLVEMENT

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

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			

*Revised April 2024

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

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			

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

*Revised April 2024

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.

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