Coastal Horizons

Promoting Choices for Healthier Lives and Safer Communities

Internal Use Only:
Received By: _____ On: _____
Date Contacted Referral Source: _____
Date Contacted Family: _____

Intensive In Home Services Referral Form

Client Name: _____ Date of Birth: _____ Age: _____ Race: _____

SS# _____ LME Record # _____ Primary Language: _____

Gender: _____ Insurance Type _____ Insurance # _____

Legal Custodian: _____ Relationship: _____

Client Address (Where services will likely take place): _____

Current Placement (i.e. Home, PRTF, Treatment Facility) _____

Phone # (home): _____ Work #: _____ Cell#: _____

Best time to contact family? _____ and Referral Source? _____

Referral Contact Name/Phone Number: _____

Current Medication(s): _____

Service Preferences: ☐ TFCBT ☐ Substance Abuse ☐ Race: _____ ☐ Sex: _____

Reason for Referral

☐ Substance Use ☐ Truancy ☐ Defiance ☐ Trauma ☐ Sexually Inappropriate Behaviors
☐ Impulsivity ☐ Runaway ☐ Suicidal/Homicidal Ideations ☐ Aggression
☐ Anxiety ☐ Depression ☐ DSS Involvement ☐ DJJ Involvement
☐ Other -

Briefly explain reason for referral: _____

Please send referral and accompanying documents to: Coastal Horizons Center: FAX: 910-202-5772

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Intensive In Home Service Definition Eligibility Criteria (FOR CHC CLINICIAN USE ONLY)

A.) Mental Health or Substance Use Disorder Diagnosis _____

B.) Has a Comprehensive Clinical Assessment been completed? ☐ Yes ☐ No
Date Completed _____ Clinician _____ Has it been requested? ☐ Yes ☐ No
Has IIH been recommended on CCA? ☐ Yes ☐ No
Has client attempted Outpatient Therapy in the past? ☐ Yes ☐ No When and with whom? _____

C.) Does client have history of symptoms/behaviors indicating need for crisis intervention? ☐ Yes ☐ No
☐ Suicidal Ideations ☐ Homicidal Ideations ☐ Physical Aggression ☐ Self Injurious Behaviors
☐ Serious Risk Taking (Running Away, Sexual Aggression, Substance Use)
Please explain all indicated above. _____

_____

_____

_____

D.) Client's behaviors are unmanageable at home (☐ Yes ☐ No) school (☐ Yes ☐ No) community (☐ Yes ☐ No)
If answered yes to any setting please explain. _____

_____

_____

_____

E.) Client is at imminent risk of out-of-home placement. ☐ Yes ☐ No
Client is currently in an out-of-home placement and return home is imminent. ☐ Yes ☐ No
Please Expalin _____

_____

_____

_____

F.) Client has participated in an alternative to IIH services in the past.
☐ MST ☐ IFPS ☐ Incredible Years ☐ TFC ☐ Hospitalization (Acute or PRTF) ☐ School Based Outpatient Therapy
☐ Residential Placement (i.e. Open House/Providence Home) ☐ Level 3 Group Home
Please explain why client is not appropriate for these services currently. _____

_____

_____

_____

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