St. Clair County Community Mental Health Authority

Challenging Behavior Referral

Individual: _____ Case #: _____ Date: _____ Does this person have a guardian? ☐Yes ☐No Is this person linked with clinical services? ☐Yes ☐No

Age: _____ Program: _____ Clinician Name: _____

Guardian Name: _____ Guardian Phone #: _____

Diagnosis: _____

Living Situation: ☐ With Family ☐ Independently ☐ HOYO ☐ Residential Setting

Group Home Name: _____ Phone #: _____

Address: _____

Caregiver/Contact Name: _____ Phone #: _____

Individual is (check all that apply):

☐ Verbal ☐ Non Verbal ☐Uses Sign Language ☐ Uses Visual Supports ☐Is In Good Health

☐ Has Seizure Disorder ☐ Has Hearing/Vision Impairment ☐ Other Medical Factors

Medications:

Reason for referral: ☐ Consultation Only ☐ Clinical Assessment ☐ Behavioral Assessment*

Explain: ***If Behavioral Assessment is being requested; Provide justification for skipping Clinical Assessment**

_____ _____

Supervisor Signature Date