Reset Form

REFERRAL FORM

Kealahou Services
CAMHD/Hawaii Dept. of Health

If you have questions about this form, please contact:
Ruth LaMer, Kealahou Services Clinical Director at (808) 733-9008

Referral Information: (self-referrals welcome)

Date of Referral: _____
Referral Name: _____
Referral Agency/Source: _____
Referral Phone: ( ) _____
Reason for Referral: _____

_____

Youth Information:

Youth's Name: _____
Youth's Date of Birth (MM/DD/YYYY): _____
Youth's Address & _____
Zip Code: _____
Youth's School Name: _____
Youth's Grade: _____
Parent/Legal Guardian Name (Print): _____
Parent/Legal Guardian Phone: ( ) _____

Trauma History:

Please check all that apply.

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Neglect
- ☐ Domestic violence
- ☐ Divorce
- ☐ Suicidal ideation/attempts
- ☐ Death
- ☐ Hospitalization/illness
- ☐ Other: _____

Symptoms may include:

Please check all that apply.

- ☐ Running away
- ☐ Truancy
- ☐ Bullying
- ☐ Trouble sleeping
- ☐ Upsetting dreams
- ☐ Hopelessness about the future
- ☐ Withdrawn and/or unusually quiet
- ☐ Avoids activities she once enjoyed
- ☐ Substance abuse
- ☐ Self-injury (i.e. cutting)
- ☐ Irritability or anger
- ☐ Other: _____

Enrollment and Eligibility Criteria:

- ☐ Trauma history or symptoms
- ☐ Displays impairment in daily functioning
- ☐ Does not have an Autism Spectrum Disorder
- ☐ Has (or may have) a DSM-5 diagnosis
- ☐ Identifies as a girl (regardless of sex)
- ☐ Is between the ages of 11-20

Agency Involvement:

Please check all that apply.

CAMHD (DOH): ☐ IDEA ☐ SEBD
Judiciary: ☐ Family Court ☐ Court-ordered
☐ Girls Court ☐ HYCF
☐ Child Welfare Services (CWS)/(DHS)
☐ School Based Behavioral Health (SBBH)/(DOE
☐ Other: _____

Additional Information:

Has the family been informed of this referral?	☐ Yes	☐ No
Has the youth expressed interest in Kealahou Services?	☐ Yes	☐ No
Has a referral been made to a CAMHD Family Guidance Center?	☐ Yes	☐ No

Please fax the following to (808) 733-9875
Attn: Kealahou Services

1) **Kealahou Services Referral form**
2) **Mental Health Assessment (within the past year)**
3) **CAMHD Family Application**

OR

Mail all forms to:
Kealahou Services
3627 Kilauea Ave, Room #101
Honolulu, HI 96816

Ver. Date: 1/2018