Local Care Team (LCT)
Referral Form

*Prior to completing the LCT Referral Form, please contact Brooke Sims, LCT Assistant, to ensure the referral is appropriate for the LCT.
Brooke can be reached at: 301.600.1077 or via email at: bsims@frederickcountymd.gov.

Check Meeting Purpose: Technical Assistance (TA) ☐ Voluntary Placement Assistance (VPA) ☐ First referral to LCT? Yes ☐ No ☐ If no, when was the date of last review? _____ Release of Information signed? Yes ☐ No ☐	Office Use Only: Case #: _____ Date of LCT Review: _____

Youth Information

Youth's Name:	Language spoken in home:	Date of Birth:	Age:
Name of Parent/Guardian:	Parent/Guardian phone number & e-mail:		
Were parent's notified of the LCT meeting? Yes ☐ No ☐	Are the Parents/Guardian attending the LCT Review? Yes ☐ No ☐		
What is the parent's expected outcome of the LCT meeting?			

Referring Agency Information

Name of Referring Agency & Name of individual making referral:	Referring individual's phone number & e-mail:	Relationship to Youth:
Name of Person Presenting Case for Review (if different than above):	Date of LCT Review Meeting:	
What is the agency's expected outcome of LCT meeting?		

Family History	
Is there any history of either mother and/or father incarceration? Yes ☐ No ☐ If yes, please explain: _____ Would the family like to receive supportive services for families impacted by incarceration? Yes ☐ No ☐	Are both parent's involved in the child's life? Yes ☐ No ☐ If no, please explain: _____
Has there been any history of substance abuse and/or alcoholism with either parent? Yes ☐ No ☐ If yes, please explain: _____	Are there other siblings in the home? If yes, please list ages: _____

Youth Strengths (Hobbies, activities, interests, grades, substance free, etc.)
Parent/Guardian Strengths (Positive relationships, community support, responsive/open to feedback, etc.)
Present Issues (Limitations, challenges, home behavior, school behavior, etc.)
Traditional and Non-Traditional Interventions Attempted (Partial Hospitalization Programs (PHP), Psychiatric Rehab Program (PRP), in home services, art, yoga, etc.)

Current Programs/Services Being Accessed (including pending services)	
History of Behavioral Health	
Residential Treatment Center (RTC) Placement: Yes ☐ No ☐	Name of placement: Date of placement: Duration of stay:
Evaluation Unit (EU) Placement: Yes ☐ No ☐	Name of placement: Date of placement: Duration of stay:
List any behavioral health hospitalizations:	
Is youth currently receiving counseling services? Yes ☐ No ☐ If yes, name of therapist:	
Is the youth currently seeing a psychiatrist? Yes ☐ No ☐ If yes, name of psychiatrist:	
Has a substance abuse assessment been given? Yes ☐ No ☐ If yes, date completed: _____ Completed by: _____ Results: _____	
Current Medications	
Diagnosis (if applicable, please spell out):	

Diagnosed by:	Date of Diagnosis:	Type of insurance:

Education

Name of current school placement:	Is youth in a specialized program? Yes ☐ No ☐	
Does youth have an IEP? Yes ☐ No ☐	Does youth have a 504 Plan? Yes ☐ No ☐	
Has FCPS or education program been notified of the LCT Review? Yes ☐ No ☐	Are any educational staff attending the LCT Review? Yes ☐ No ☐	
Name of person notified?:	Phone:	Email:

Signature of individual completing form: _____ Date: _____

This section is to be completed by the DSS presenter for VPA requests ONLY.

A copy of the DSS presenter comments/recommendations will be submitted to OCF.

☐ To Parent (s)	Date & Method of Notice:	☐ Guardian (s)	Date & Method of Notice:	☐ Attorney	Date & Method of Notice:

☐ Out of State placement discussion, to parent(s), guardian(s) attorney	Date:	Method of Notice:
☐ Waiver of notice requirements received, if applicable (completed by DSS)	Date:	

LCT Meeting Comments

List General Recommendations