**Seneca Family of Agencies dba Seneca OC North**

**Guided Animal Intervention Therapy (GAIT)**

**Referral Form**

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| **PLEASE FILL OUT COMPLETELY AND ATTACH ADDITIONAL DOCUMENTATION TO SUPPORT REFERRAL**  SUBMIT ALL DOCUMENTATION TO: [gait@senecacenter.org](mailto:gait@senecacenter.org) or fax to 714-619-8400  Rehabilitation Support Services (Rehab) are one-to-one, intensive, time-limited mental health services for clients who are deemed eligible by their primary therapist. These youth may have serious emotional problems, be experiencing a stressful transition, or may be struggling with living skills resulting in behavioral concerns at school and/or at home impacting their ability to meet their goal established by their primary therapist. Services are provided in collaboration with the primary caregivers, school staff, and any existing mental health providers to develop and reinforce skills through providing thoughtful interventions to manage behaviors effectively. Rehab ends when the treatment team agrees that measurable outcome goals have been met or if it is decided that the service is no longer effective. | | | | | |
| Identifying Data | | | | | |
| Child/Youth Name: | | | | DOB: | MRN: |
| Ethnicity: | | Language Preference: | | | Gender: |
| Medi-Cal Number/CIN: | | | | | |
| **Current Placement** | | | | | |
| Caregiver name: | Address: | | | | |
| Telephone number (primary): | | | Alternate Telephone number: | | |
| Has this client been determined to meet criteria for Intensive Case Coordination (ICC)? Choose an item. | | | | | |

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| Does child/youth have social worker? Choose an item. | Name of Social Worker: | |
| Phone: | Email: |

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| |  |  | | --- | --- | | **Primary Mental Health Provider Section**  Youth served by Rehab must have a primary therapist. *Rehab is most effective when there is a strong partnership between the primary mental health provider and the Mental Health Worker.* | | | Name of Mental Health Provider: | | | Phone: | Email: |   **Most Recent DSM V Diagnosis** | |
| Axis I (Primary): | . |
| Axis I: |  |
| **Reason for referral to GAIT:** | |
| **Please identify areas of significant history or need affecting behaviors:**  Activities of Daily living (for client/parent)  Social and Leisure Activities  Grooming/personal Hygiene  Accessing/using Support Resources  Medication Education  Independent Living Skills  Support in generalizing skills  Other (please explain below) | |
| **Please provide a brief description of behavior(s):** | |
| **Please provide expected outcomes/goals of GAIT services:** | |

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| **Interested in** *(please select* ***only one****)***:**  Individual sessions  Group Sessions  Individual or Group Sessions  **Availability** *(please select* ***all that apply****)***:**  Tuesdays AM  Wednesdays AM  Thursdays AM  Fridays AM  Saturdays AM  Tuesdays PM  Wednesdays PM  Thursdays PM  Fridays PM  Saturdays PM |

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| *Agreement for REHAB\*\*\*\** | | | | | |
| I agree to provide clinical direction to the Mental Health Worker assigned to provide REHAB services. I understand that I am a member of the Child and Family Team and will be available for consultation on a weekly basis with the MHW. I confirm that I have attached the following documents to this request:  A copy of the *most current* Assessment, including REHAB services  A copy of the Treatment Plan, including **Intensive Care Coordination/Targeted Case Management *and* Intensive Home-Based Services/Rehab**  A copy of the *most recent* CANS  A copy of client’s Medi-Cal card  Pathways to Well Being/Intensive Services Eligibility Assessment  A copy of the Financial Evaluation Form/SOU (UMDAP forms) \**n/a for clients who are in foster or group home*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Primary Therapist Print Name Date | | | | | |
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