MH-JJ REFERRAL SCREEN

Revised 03/20

FAX REFERRAL TO: 312-338-0326 Attn: Agoritsa Barczak, Psy.D.

If you mark a 'Yes' to any of the following, please fax this form to make a referral to the MHJJ Program:

	YES	NO
Current or prior diagnosis of Schizophrenia or Psychosis…………..…	☐	☐
Current or prior diagnosis of Depression, Anxiety or Bipolar Disorder	☐	☐
Youth is currently on any psychotropic medication…………………...	☐	☐
Sad or depressed emotionally……………………………………….….	☐	☐
Very irritable emotionally……………………………………………..….	☐	☐
Withdraws from / avoids contact with others…………………………	☐	☐
Sleep difficulties ………………………………………………………	☐	☐
Nightmares……………………….………………………...………..	☐	☐
Hearing voices or other sounds that are not real……………………….	☐	☐
Seeing things that are not real…………………………………….……	☐	☐
Reporting strange sensations (e.g. things crawling on them) ……..…..	☐	☐
Bizarre behavior…………………………………………………….	☐	☐
Unusual or difficult to follow speech…………………………….…	☐	☐
Strange appearance or mannerisms……………………………..…..	☐	☐
Rapid or pressured speech………………………………………	☐	☐
Extreme grandiosity…………………………………………………..	☐	☐
Inability to control him/herself……………………………………….	☐	☐
Excessive fear or anxiety…..…………………………………….....	☐	☐

MHJJ Liaisons Only

Is youth eligible for CSPI?

YES NO

History of Exposure to Potentially Traumatic Life Events, for example:	YES	NO
crime victim, witnessed/experienced abuse, severe neglect, domestic or community violence	☐	☐

THE PERSON MAKING THIS REFERRAL SHOULD COMPLETE ALL SECTIONS BELOW:

YOUR NAME:__________________________ Your Role/Title: _________________________

Your Phone #: _________________ Today's Date: _______________

YOUTH's NAME: _______________________ Gender: ☐M ☐F Location__________________

Date of Birth: __/___/____ Age: ______ Diagnosis:_______________ Medication: ________________

PO: ________________________________ PO Phone #:_____________________

Calendar/Judge__________________ Next Court Hearing: ___/_____/______

PARENT/GUARDIAN CONTACT INFORMATION:

Name: _____________________________________ Primary Language: ___________________

Phone: (____) _______-________ Other phone # (i.e. cell): (____) _______-________

Address: ___________________________________ City: _______________________________

PLEASE CALL Dr. Agoritsa Barczak at 312-814-1646 IF YOU HAVE ANY QUESTIONS.

OFFICE USE ONLY: Liaison: _________________ Date Assigned to Liaison: ___/____/________

DHS/DMH Contact: Dr. Agoritsa Barczak at 312-814-1646 or Agoritsa.barczak@illinois.gov