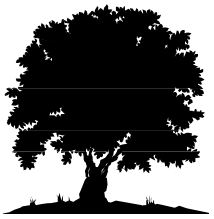

*The Center for Personal Growth*
4656 30th St., San Diego, Ca. 92116
*Telephone: (619) 528-8005*
*Fax: (619) 528-8054*

## Before completing the Skills System Group Referral Form, please complete the inclusion and exclusion criteria listed below:

**Inclusion Criteria (check all that apply):**

The client is dually diagnosed (developmental disability and co-occurring psychiatric diagnosis) and be able to provide documentation of these diagnoses. ☐ Yes ☐ No

The client has the ability to participate in group therapy (i.e. sitting, attending, answering questions, participating, etc.) ☐ Yes ☐ No

The client has an open and active case with the San Diego Regional Center. ☐ Yes ☐ No

**Exclusion Criteria (check all that apply):**

The person has a history of being AWOL and this issue is part of the person's current treatment plan/interventions. ☐ Yes ☐ No

The person has a high degree of self injurious behavior management as part of their current treatment plan/interventions. ☐ Yes ☐ No

The person has a high degree of physical or verbal aggression, property destruction, or recent incidents as part of their current treatment plan/interventions. ☐ Yes ☐ No

The person has a seizure disorder not reliably controlled by medication. ☐ Yes ☐ No

The person requires assistance with bathroom use. ☐ Yes ☐ No

The person has a history of fire setting behavior. ☐ Yes ☐ No

The person has a history of inappropriate sexual behavior. ☐ Yes ☐ No

The person has problematic substance abuse. ☐ Yes ☐ No

The person does not use words to communicate and does not have appropriate facilitation available. ☐ Yes ☐ No

If you answered "Yes" to any exclusion criteria, please provide details:

_____

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# Skills System Group Referral Form

**General Information:**

Name: _____

Address: _____

Telephone (Day/Evening/Cell):_____

Date of Birth:_____

Type of residence:_____

Email (Optional):_____

**Emergency Contact Information:**

Name:_____

Relationship to client:_____

Telephone (Day/Evening/Cell):_____

**Support People:**

Name: _____ Tel.#:_____ Relationship:_____

Name: _____ Tel.#:_____ Relationship:_____

Part of the requirement for enrolling a client in the Skills System program is that they have a Designated Support Person for this program. This person should be someone who knows the client well and has frequent and regular contact with the client. This person will be required to accompany the client to and participate in the Skills System Support Person's group once per month on a designated Wednesday night from 6:00 pm to 7:00 pm. Who will be the client's designated support person:

Name: _____ Tel.#:_____ Relationship:_____

**Legal Representative:**

Does the client have a conservator or is the client a minor who needs parental consent to receive therapy services?

☐ Yes If Yes…YOUR CONSERVATOR MUST ATTEND THE INTIAL SCREENING APPT.
☐ No

If Yes, please provide the following information:

*The Center for Personal Growth*
4656 30th St., San Diego, Ca. 92116
*Telephone: (619) 528-8005*
*Fax: (619) 528-8054*

Name of conservator or legal representatives:
_____

Telephone number of conservator or legal representative: _____

Note to SDRC Service Coordinator:

Thank you for referring this client to the Skills System Group. Please submit two POS' for these services (one for group therapy services and one for individual therapy services). The initial POS for group therapy services should be submitted for 64 units and have a time frame of one year. The initial POS for individual therapy services should be for 34 units (14 initial units and two estimated additional increments of 10 units each) and should also have a time frame of one year. Please use the date of the referral form as the start date for these POS'. Our vender number with the SDRC is: PQ9550. In addition, please forward the following collateral information:

- Consumer Information Sheet
- Individual Program Plan (IPP)
- Individual Program Plan (IPP) Services and Supports Form
- Client Developmental Evaluation Report (CDER)
- Psychological Report/Evaluation
- Behavior Assessment
- Social Summary/Assessment
- Medical Evaluation

By signing below, I certify that I have submitted the requested POS' for approval and requested collateral information be sent to the Center For Personal Growth.

SDRC SC Print Name:_____

SDRC SC Signature:_____ Date:_____

Tel.#:_____

☐ 4355 Ruffin Road, San Diego, Ca. 92123
☐ 8760 Cuyamaca St, #100, Santee, Ca. 92071
☐ 2727 Hoover Ave, #100, National City, Ca. 92150
☐ 5931 Priestly Drive, Suite 100, Carlsbad, CA 92008

Thank you for completing the Skills System Group Initial Screening Form. You have three options to submit this form:

1. Fax this form to The Center for Personal Growth, Inc. at 619-528-8054.
2. Mail this form to the address listed above.
3. Scan this form and email it to BNewcomer@centerforpg.com.

This information will be reviewed by a Skills System staff member who will contact you to discuss the content and/or schedule an initial screening appointment with the client.