**Designated & Enhanced**

**Women’s Specialty Services**

**Children’s Referral Report**

This report is due **quarterly** for all Mid-State Health Network substance use disorder treatment providers offering Gender Competent, Designated and/or Enhanced Women’s Specialty services.

SUBMIT REPORT TO: Rebecca.emmenecker@midstatehealthnetwork.org

**Due Dates:** 10/05, 01/05, 04/05, 07/05

Fiscal Year & Quarter for Submission: **FY** \_\_\_\_\_\_\_\_ **Quarter:** 1  2 3 4

Site locations included in this report (for providers with more than one location): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Program |  |
| Address |  |
| Contact |  |
| Phone |  |
| Email |  |
| Date Submitted |  |

**Instructions:**

1st Row: indicate the total number of children referred for each service category listed across the top. There may be some “duplication” if a child is referred for more than 1 serve.

2nd Row: indicate the number of children (parents) who accessed the service they were referred to. This will require follow up with the family.

3rd Row: indicate the number of children (parents) who refused the service they were referred to.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Prevention Services | Treatment Services | Mental Health Services | Other |
| # of children referred for to: |  |  |  |  |
| # of children who accessed: |  |  |  |  |
| # of children who refused: |  |  |  |  |

Please describe efforts taken to improve outcomes over the reporting period:

Please describe any programming implementations planned to help improve outcomes for the future reporting period:

Please identify any technical assistance needs for program implementation: