

## Request for a Local Care Team Meeting (LCT)

*Please fax this form to: 443-692-0095 or complete on line at [www.flbcinc.org](http://www.flbcinc.org)*

<b>Child's Name :</b>				<b>Date:</b>			
<b>Date of Birth:</b>		<b>SSN:</b>		<b>Gender:</b>		<b>Race:</b>	
<b>Address:</b>							
<b>State:</b>		<b>Zip code:</b>		<b>Phone:</b>			
<input type="checkbox"/> <b>Parent/Guardian</b> <b>Address:</b> _____ <b>Phone:</b> _____							
<input type="checkbox"/> <b>Parent/Guardian</b> <b>Address:</b> _____ <b>Phone:</b> _____							
<input type="checkbox"/> <b>Other</b> <b>Address:</b> _____ <b>Phone:</b> _____							

<b>Who is requesting the LCT Meeting?</b> Please provide contact information including phone number:	<b>What is your relationship with this individual?</b>  Do you have the individual's (ages 18-21) or guardian's permission to discuss this child? Y or N
---	--

<b>Please list those other individuals, including contact information, whom you would like to be invited to the LCT meeting (including the child's lawyer for DJS):</b>
---

<b>Does your child receive Medical Assistance?</b> Y or N	<b>Does your child receive SSI?</b> Y or N
---	--

<p><b>Current school</b></p>																											
<p><b>Please list any medical conditions</b></p>	<table border="0"> <tr> <td><input type="checkbox"/> Anemia-(low iron)</td> <td><input type="checkbox"/> High Cholesterol</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> Allergy</td> <td><input type="checkbox"/> Immune Disorder</td> </tr> <tr> <td><input type="checkbox"/> Birth Defects</td> <td><input type="checkbox"/> Kidney Disorder</td> </tr> <tr> <td><input type="checkbox"/> Bleeding problems</td> <td><input type="checkbox"/> Lead Poisoning</td> </tr> <tr> <td><input type="checkbox"/> Cerebral Palsy</td> <td><input type="checkbox"/> Seizures</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Speech Disorder</td> </tr> <tr> <td><input type="checkbox"/> Ear Infections</td> <td><input type="checkbox"/> Sexual Transmitted Disorder (STD)</td> </tr> <tr> <td><input type="checkbox"/> Food Allergy</td> <td><input type="checkbox"/> Thyroid Disorder</td> </tr> <tr> <td><input type="checkbox"/> Genetic Disorder</td> <td><input type="checkbox"/> Vision Problems</td> </tr> <tr> <td><input type="checkbox"/> Head Aches</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Head Injuries</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Hearing Problems</td> <td></td> </tr> </table>	<input type="checkbox"/> Anemia-(low iron)	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Allergy	<input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Seizures	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Speech Disorder	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Sexual Transmitted Disorder (STD)	<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Head Aches	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Head Injuries		<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Anemia-(low iron)	<input type="checkbox"/> High Cholesterol																										
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure																										
<input type="checkbox"/> Allergy	<input type="checkbox"/> Immune Disorder																										
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Kidney Disorder																										
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Lead Poisoning																										
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Seizures																										
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Speech Disorder																										
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Sexual Transmitted Disorder (STD)																										
<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Thyroid Disorder																										
<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Vision Problems																										
<input type="checkbox"/> Head Aches	<input type="checkbox"/> Other: _____																										
<input type="checkbox"/> Head Injuries																											
<input type="checkbox"/> Hearing Problems																											
<p><b>Please list any behavioral concerns</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Argues or is verbally disrespectful</li> <li><input type="checkbox"/> Doesn't participate in activities that were previously enjoyable</li> <li><input type="checkbox"/> Gets into physical fights with peers or family members</li> <li><input type="checkbox"/> Steals or lies</li> <li><input type="checkbox"/> Is aggressive toward adults</li> <li><input type="checkbox"/> Has participated in self-harm (e.g. cutting or scratching self, attempted suicide)</li> <li><input type="checkbox"/> Appears sad or unhappy</li> <li><input type="checkbox"/> Has a negative or distrustful attitude toward friends, family members, or adults</li> <li><input type="checkbox"/> Threatens to or has run away from home</li> <li><input type="checkbox"/> Deliberately breaks rules, laws, or expectations</li> <li><input type="checkbox"/> Engages in inappropriate sexual behavior (e.g. sexually active, exhibits self, sexual abuse toward family members or others)</li> <li><input type="checkbox"/> Is irritable</li> <li><input type="checkbox"/> Becomes angry enough to be threatening to others</li> </ul>																										

	<input type="checkbox"/> Has difficulty concentrating, thinking clearly, or attending to tasks <input type="checkbox"/> Seems to stir up trouble when bored <input type="checkbox"/> Is unusually demanding <input type="checkbox"/> Complains of nightmares, difficulty getting to sleep, oversleeping, or waking up from sleep too early <input type="checkbox"/> Is overly anxious or nervous <input type="checkbox"/> Has friends of whom I don't approve <input type="checkbox"/> Doesn't have or keep friends <input type="checkbox"/> Has difficulty waiting his/her turn in activities or conversations <input type="checkbox"/> Other: _____
<p><b>Please list any substance use</b></p>	
<p><b>Please list what services or agencies he/she has been involved in up to now</b></p>	

<p><b>Meeting Purpose</b></p>	
<p><b>Please explain why you are requesting an LCT meeting:</b></p>	

This request will be reviewed by the LCT at our next scheduled weekly meeting. In general, the team meets on Tuesdays. We will respond to you by phone and/or mail. To leave a voice mail for the LCT call: 443-423-0921