

CHILDREN'S SERVICES REFERRAL APPLICATION

Date of Referral:

Date Placement is Needed:

Type of Referral:

Other Type of Referral:

Referring Agency:

Other Referring Agency:

If client is in DSS custody, has the ISCEDC team approved placement? Yes No

Case Manager's Name:

Region:

Phone Number:

Fax Number:

E-Mail:

Address:

CLIENT INFORMATION

Client's Name:

AKA/Nickname:

Social Security Number:

Medicaid Number:

Medical Insurance Policy Carrier, Number(s), Holder:

Date of Birth:

Age:

Gender:

Race:

Height:

Weight:

Religious Affiliation:

Other Religious Affiliation:

Place of Birth:

County of Legal Custody:

Legal Custodian:

Relationship to Client:

Address:

Telephone Number:

E-Mail Address:

Distinguishing features (i.e., scars, tattoos, birthmarks, etc.):

Hobbies:

CLIENT INFORMATION (continued)

CURRENT BEHAVIORAL PROBLEMS/WEAKNESSES (Check all that apply. **If a behavior has an asterisk beside it, include an explanation of the circumstances/situation in the space below the chart.**):

- | | | |
|---|---|---|
| <input type="checkbox"/> Abandonment Issues | <input type="checkbox"/> Aggressive (Physical) | <input type="checkbox"/> Aggressive (Sexual) |
| <input type="checkbox"/> Aggressive (Verbally) | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Antisocial Behavior |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> *Arson | <input type="checkbox"/> *Bedwetting |
| <input type="checkbox"/> Below Grade Level | <input type="checkbox"/> Cruelty to Animals | <input type="checkbox"/> Delusional |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Destroys Property | <input type="checkbox"/> Difficulty with Authority |
| <input type="checkbox"/> *Developmentally Delayed | <input type="checkbox"/> *Fire Setting | <input type="checkbox"/> Functionally Illiterate |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Loss/Grief Difficulties | <input type="checkbox"/> *Low IQ/Mental Retardation |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Oppositional/Defiant | <input type="checkbox"/> Parental Neglect Issues |
| <input type="checkbox"/> Phobic Reactions/Behavior | <input type="checkbox"/> Physical Disability: (specify) | <input type="checkbox"/> Poor Coping Skills |
| <input type="checkbox"/> Poor Personal Hygiene | <input type="checkbox"/> Problems at School | <input type="checkbox"/> Poor Reality Orientation |
| <input type="checkbox"/> Poor Social Skills | | <input type="checkbox"/> Running Away |
|
 | | |
| <input type="checkbox"/> Self-Destructive Behavior | <input type="checkbox"/> *Sexually Acts Out | <input type="checkbox"/> Sexually Provocative |
| <input type="checkbox"/> Sibling Related Difficulty | <input type="checkbox"/> Suicidal Gestures | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Truancy | <input type="checkbox"/> Unruly/Ungovernable |
| <input type="checkbox"/> Other: (specify) | <input type="checkbox"/> Other: (specify) | <input type="checkbox"/> Other: (specify) |

Explanation:

Client has been a victim of (check all that apply):

- | | | | |
|--|-------------------------------------|--|--------------|
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated | Perpetrator: |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated | Perpetrator: |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated | Perpetrator: |
| <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated | Perpetrator: |

MEDICAL INFORMATION

DSM IV DIAGNOSIS:

	Diagnosis	Date Given	Source
Axis I			
Axis II			
Axis III			
Axis IV			
Axis V			

MEDICATIONS (list all current medications, dosages, and instructions. **If additional medications needed see page 10**):

Medication Name	Dosage	Instructions

List any known, pre-existing medical conditions/physical disabilities that would place the client at a greater risk during restraint or seclusion.

Describe any known history of sexual or physical abuse that would place the client at greater psychological risk during restraint or seclusion.

MEDICAL CONDITIONS (check all that apply): C = Current H = History of T = Being Treated for

- | | | | | | |
|--|--|--------------|--|-------------|--|
| Anemia | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Anorexia | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Asthma | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Bulimia | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Chicken Pox | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Convulsions | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Diabetes | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Eczema | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Encopresis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Enuresis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Fainting | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Hay Fever | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Headaches | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Hepatitis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | HIV/AIDS | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Lice | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Measles | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Mumps | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Pink Eye | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Pregnancy | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Ringworm | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Seizures | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Sinusitis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Sore Throat | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| STD(s) | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Tuberculosis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Other: (specify) | | | | |
| <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Other: (specify) | | | | |
| <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Other: (specify) | | | | |

Date of Last Physical Exam:

Dental Exam:

Eye Exam:

Dental Appliances: Yes No

Contacts/Glasses: Yes No

Allergies

Special Dietary Needs:

FAMILY INFORMATION

Biological Mother's Name:

Address:

Telephone Number:
Educational Level (if known):

Race:
Criminal Record: Yes No

Biological Father's Name:

Address:

Telephone Number:
Educational Level (if known):

Race:
Criminal Record: Yes No

Are the Biological Parents: Married Separated Divorced:
 Deceased (which one): Other (specify):

Have Parental Rights Been Terminated? No Yes (If yes, date)

Name of Siblings	Placement (if applicable)

FAMILY STRENGTHS

FAMILY INFORMATION (continued)

FAMILY CONTACT

Significant Family Member(s) and Relationship to Client	Address	Phone Number	Type of Contact with Client (phone, letters, face-to-face, etc.)

OTHER APPROVED CONTACTS

Name and Relationship to Client	Address	Phone Number	Type of Contact with Client (phone, letters, face-to-face, etc.)

Are there any special conditions/restrictions for home visits or furloughs?

There is a family history of (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Child Abuse/Neglect | <input type="checkbox"/> Criminal Activity |
| <input type="checkbox"/> Inappropriate Sexual Behavior | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Treatment Disruption | <input type="checkbox"/> Other: (specify) |

Brief family history:

SCHOOL INFORMATION (CONFIDENTIAL AND NONTRANSFERABLE)

Client Name:		Gender:		Race:	
Date of Birth:					
Legal Custodian:				Case Manager Name:	
Agency:					
Agency Address:					
Phone:		Fax:		E-Mail:	

Home School District of Origin:

List last five schools attended beginning with the most recent:

PLACEMENT	DATES	SCHOOL ATTENDED	DELIVERY MODEL *

Is client currently classified Special Education? No Yes Unk IF YES, list primary classification in the space below:

Has client ever been classified Special Education? No Yes Unk
 Does client have current IEP? No Yes Unk IF YES, date: _____
 Does client have section 504 Plan? No Yes Unk IF YES, date: _____
 Does client have history of truancy? No Yes Unk
 Has client ever been suspended? No Yes Unk
 Is client currently under recommendation for expulsion? No Yes Unk For what? (Enter the reason in the space below.)

Is the client functioning at grade level? No Yes If below, please indicate grade level: _____

IQ/ACHIEVEMENT/ADAPTIVE TESTING

Name of Test	Date	Given By:	Scores and Ranges, e.g., Low. Average, etc.

Is the IQ score considered valid by the examiner? No Yes (If not, explain below.)

Medical Conditions:

Current Medications:

This page is to be provided to the receiving school district along with the signed Authorization for Release of School Information

AGENCY/COURT INVOLVEMENT

AGENCIES CURRENTLY INVOLVED WITH CLIENT

CCRS COC DDSN DJJ DMH DSS DSS-MTS Voc. Rehab
Other: (specify)

Has the client ever been to court? No Yes-Type of court and outcome:

Does the client have pending charges? No Yes-list charges:

Is placement court ordered? No Yes-attach copy of the order

TREATMENT GOALS

Client's Goals	
Family's Goals (if applicable)	
Agency's Goals	
Educational Goals	

**ADMISSION REQUIREMENTS CHECKLIST
(TO BE FORWARDED IF CLIENT IS ACCEPTED FOR PLACEMENT)**

The referring agency will make every reasonable effort to supply the items listed in the Admission Requirements Checklist if the client is accepted for placement. If more information than is provided in the Children's Services Referral Application is required to determine client eligibility for admission, the provider agency should request in writing the additional information from the referring agency.

ADMISSION REQUIREMENTS CHECKLIST (IF ACCEPTED FOR PLACEMENT)	
Medical Exam	<input type="checkbox"/>
Most Recent Treatment Plan	<input type="checkbox"/>
Current Medicaid /Insurance Card	<input type="checkbox"/>
Medical Necessity Form	<input type="checkbox"/>
254 Authorization Form	<input type="checkbox"/>
Most Recent Psychological/Psychiatric Evaluation(s)	<input type="checkbox"/>
Previous Placement Discharge Summary(ies)	<input type="checkbox"/>
Individual Education Plan (if applicable)	<input type="checkbox"/>
Copy of Birth Certificate	<input type="checkbox"/>
Copy of Social Security Card	<input type="checkbox"/>
Immunization Records	<input type="checkbox"/>
Completed Consent Forms (Program should forward to referring agency prior to admission)	<input type="checkbox"/>
Copies of Court Orders	<input type="checkbox"/>
Signed Homebound Form (if applicable)	<input type="checkbox"/>
Pre-Admission Assessment (if applicable)	<input type="checkbox"/>

Name of Person Making Application:

Relationship to Client:

Telephone:

Address:

Signature: _____ Date: _____

