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)

Strengths: (Check all that apply)

- ☐ Strong Family Base
- ☐ Appropriate Reading Level
- ☐ Average/Above IQ
- ☐ Other (specify)
- ☐ On Grade-Level
- ☐ Good Verbal Skills
- ☐ Good Personal Hygiene
- ☐ Good Socialization Skills
- ☐ Appropriate Coping Skills

Reason for Referral:

CLIENT'S CURRENT PLACEMENT:

Facility (A-E):
Facility (F-La):
Facility (Lu-N)
Facility (O-Sl)
Facility (So-Wild)
Facility (Will-Y)
☐ Home
☐ Other (specify in the space to the right):

Level of care: Other Level of Care:

Number of Previous Placements:

Placement History (Please list all placements including psychiatric hospitalizations. Attach additional page(s) if necessary. **Go to page 10 to continue**)

Placement	Dates (From/To)		Reason for Discharge

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.)**:

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

Explanation:

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

☐ Neglect	☐ Allegation	☐ Substantiated	Perpetrator:
☐ Physical Abuse	☐ Allegation	☐ Substantiated	Perpetrator:
☐ Sexual Abuse	☐ Allegation	☐ Substantiated	Perpetrator:
☐ Emotional Abuse	☐ Allegation	☐ 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	☐C ☐H ☐ T	Anorexia	☐C ☐H ☐ T	Asthma	☐C ☐H ☐ T
Bulimia	☐C ☐H ☐ T	Chicken Pox	☐C ☐H ☐ T	Convulsions	☐C ☐H ☐ T
Diabetes	☐C ☐H ☐ T	Eczema	☐C ☐H ☐ T	Encopresis	☐C ☐H ☐ T
Enuresis	☐C ☐H ☐ T	Fainting	☐C ☐H ☐ T	Hay Fever	☐C ☐H ☐ T
Headaches	☐C ☐H ☐ T	Hepatitis	☐C ☐H ☐ T	HIV/AIDS	☐C ☐H ☐ T
Lice	☐C ☐H ☐ T	Measles	☐C ☐H ☐ T	Mumps	☐C ☐H ☐ T
Pink Eye	☐C ☐H ☐ T	Pregnancy	☐C ☐H ☐ T	Ringworm	☐C ☐H ☐ T
Seizures	☐C ☐H ☐ T	Sinusitis	☐C ☐H ☐ T	Sore Throat	☐C ☐H ☐ T
STD(s)	☐C ☐H ☐ T	Tuberculosis	☐C ☐H ☐ T		☐C ☐H ☐ T

☐C ☐ H ☐ T Other: (specify)
☐C ☐ H ☐ T Other: (specify)
☐C ☐ H ☐ 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):

☐ Child Abuse/Neglect
☐ Inappropriate Sexual Behavior
☐ Treatment Disruption
☐ Criminal Activity
☐ Psychiatric Illness
☐ Other: (specify)

Brief family history:

SCHOOL INFORMATION (CONFIDENTIAL AND NONTRANSFERABLE)

Client Name:
Date of Birth: Gender: Race:
Legal Custodian:
Agency: Case Manager Name:
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	☐
Most Recent Treatment Plan	☐
Current Medicaid /Insurance Card	☐
Medical Necessity Form	☐
254 Authorization Form	☐
Most Recent Psychological/Psychiatric Evaluation(s)	☐
Previous Placement Discharge Summary(ies)	☐
Individual Education Plan (if applicable)	☐
Copy of Birth Certificate	☐
Copy of Social Security Card	☐
Immunization Records	☐
Completed Consent Forms (Program should forward to referring agency prior to admission)	☐
Copies of Court Orders	☐
Signed Homebound Form (if applicable)	☐
Pre-Admission Assessment (if applicable)	☐

Name of Person Making Application:

Relationship to Client: Telephone:

Address:

Signature:_____ Date:_____

Additional Placements:

Placement	Dates (From/To)		Reason for Discharge

Additional Medications:

Medication Name	Dosage	Instructions