



Today's Date:

Date Placement Needed By:

Referral

All information contained in this placement referral is strictly confidential. Please fax to ensure continued confidentiality.

Youth Name <i>(First, Middle, Last)</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	Age:
Type of Referral:	<input type="checkbox"/> 35 Day Evaluation	<input type="checkbox"/> Stabilization/90 Day Intensive Treatment	<input type="checkbox"/> Secure Detention	<input type="checkbox"/> Professional Foster Care
	<input type="checkbox"/> Girls Program	<input type="checkbox"/> Residential Treatment Cottage	<input type="checkbox"/> Boys Program	<input type="checkbox"/> Teens In Transition
			<input type="checkbox"/> Specialized Foster Care	
Youth S.S. Number:	Race:	If applicable, Tribe:		
Youth's Current Residence:				

INFORMATION

Referral Source Name:				
Title:	<input type="checkbox"/> SW	County	<input type="checkbox"/> CMH	County
	<input type="checkbox"/> PO	County	<input type="checkbox"/> Parent	Custody Type
	<input type="checkbox"/> TW	Tribe	<input type="checkbox"/> Other:	

Referral Contact Information	
Direct Line:	Mailing Address:
Cell:	Email Address:
Fax:	

Type of Placement: Court Order Social Service Voluntary Other:

A copy of the hold/placement agreement will be required upon placement. This includes ICPC paperwork.

FAMILY INFO:	ADOPTIVE/BIO/STEP	MAILING ADDRESS	DATE OF BIRTH
Father			Has Custody <input type="checkbox"/>

Full Name: Home Phone: Cell Phone: TPR: Yes No In Process

Mother		Has Custody <input type="checkbox"/>
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Full Name: Home Phone: Cell Phone: TPR: Yes No In Process

Siblings	<input type="checkbox"/> M		Limits to contact
	<input type="checkbox"/> F		Limits to contact
	<input type="checkbox"/> M		Limits to contact
	<input type="checkbox"/> F		Limits to contact

Are there any restrictions on either parent's involvement? If so, please indicate here:

Referral Source Narrative:

Youth's Previous Placements		
Year	Reason	Agency / Location
Has youth received previous services from NHCFS in either Bemidji or Duluth locations? If yes, indicate below. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Youth's Previous Offenses		
Year	Offense	Outcome
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength / Mg	Frequency Taken
Allergies		
To	Reaction Had	

HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.					
Abuse History	<input type="checkbox"/> Neglect	Perpetrator(s):			
	<input type="checkbox"/> Physical	Perpetrator(s):			
	<input type="checkbox"/> Emotional/Psychological	Perpetrator(s):			
	<input type="checkbox"/> Sexual	Perpetrator(s):			
Risk of Harm to Self	Is there a history of cutting or self injurious behavior (SIB)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there a history of suicidal ideation?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of suicide attempts?				
	Current risk of suicide	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
FASD	<input type="checkbox"/> None	<input type="checkbox"/> Suspected	<input type="checkbox"/> Requesting Diagnosis	<input type="checkbox"/> Has Diagnosis	
	If diagnosed, name of Diagnostic Clinic/Professional?				
Risk of Harm to Others	History of Sexual Behaviors or Talk?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, please describe?				
	Has the youth successfully completed treatment to address the behaviors/talk?				
	History of cruelty to animals?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Verbally abusive to others?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physically abusive to others?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Gang involvement?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Difficulties with peer relationships?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Run Risk	History of running away?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Recent – time gone:	<input type="checkbox"/> months ago:	<input type="checkbox"/> years ago:	<input type="checkbox"/> N/A:	
	# of runs:	Places youth goes:			
Homelessness	Does the youth have a history of being homeless?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drugs / Alcohol	Does youth currently use recreational or street drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does youth currently use alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mental Health	Does the youth have an eating disorder or suspected eating disorder?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does the youth have grief or loss suffering?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If so, describe loss and month/season it occurred:				
	Does the youth have difficulty with parental relationships?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Additional Questions	Lying or Cheating concerns?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Enuresis or Encopresis history/current concern?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does the youth have vision or hearing loss?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does the youth have history of gang involvement?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there a history or concern of truancy or lack of academic motivation?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does the youth have identity issues?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is there a current diagnostic/functional assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	Clinic/Doctor:
Specific goals for the youth to accomplish:	Is youth on an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Strengths of youth/family:		
Physical restrictions for the youth:	The developmental and mental health needs can be met by our program. <input type="checkbox"/> Yes <input type="checkbox"/> No	

INSURANCE INFORMATION		
Name of Primary Insurance:		
Is this a PMAP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the placement been approved by the PMAP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you requested a faxed confirmation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Address of Insurance:	Telephone number:	
Name of Insured:	Relationship to Youth:	Insured DOB:
Insured ID Number:	Group Number:	Name of Insured Employer:
Is there a Secondary Insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Secondary Insurance:		
Address of Insurance:	Telephone number:	
Name of Insured:	Relationship to Youth:	Insured DOB:
Insured ID Number:	Group Number:	Name of Insured Employer:

REQUESTED ADDITIONAL SERVICES		
Additional services requested. Specific information can be added in the space provided.		
<input type="checkbox"/> Psychological Diagnostic:	<input type="checkbox"/> Family Assessment:	<input type="checkbox"/> Medication Management:
<input type="checkbox"/> Psychiatric Diagnostic:	<input type="checkbox"/> Individual Therapy:	<input type="checkbox"/> FASD Diagnostic Assessment:
<input type="checkbox"/> Rule 25 and/or CD Care:	<input type="checkbox"/> Family Therapy:	<input type="checkbox"/> Specific Medical/Dental Care:
<input type="checkbox"/> CTSS/MHBA:	<input type="checkbox"/> Adoption Services:	<input type="checkbox"/> Other: