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| NH logo small.jpg | | | | | | | | | | | | | Today’s Date: | | | |
| Referral *All information contained in this placement referral is strictly confidential. Please fax to 218-327-1871 or e-mail to* [*connie.ross@northhomes.org*](mailto:connie.ross@northhomes.org)*.* *For Boys Program, TNT, or Next step please email to* [*suzette.mallum@northhomes.org*](mailto:suzette.mallum@northhomes.org) | | | | | | | | | | | | | | | | |
| Youth Name (First, Middle, Last) | | Identifies as  **Pronouns:** | | | | | | | M  F | | | DOB: | | **Age:** | | |
| Type of Referral: | 35 Day Evaluation  Stabilization/Shelter  SEY Transition Living Hawkins/ Winnie Sisu  Residential Treatment  Boys Program, TNT, Next Step | | | | | | | | | | | | | | | |
| Youth S.S. Number: | | | | |  | Race:       If applicable, Tribe: | | | | | | | | |  | |
| Youth’s Current Placement: | | | | | | | | | | | | | | | | |
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| Information | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Referring Agency: Worker’s Name** | | | | | | | **Phone/ Email:** | | | | | | | | |
| Referral Agency Contact Information: | | | | | | | | | | | | | | | | |
| Direct Line:       Mailing Address: | | | | | | | | | | | | | | | | |
| Cell:       Email Address: | | | | | | | | | | | | | | | | |
| Other Professionals Currently Working with this Child: | | | | | | | | | | | | | | | | |
| Agency: Workers Name: Phone/ Email: Involved in Treatment:  Yes  No | | | | | | | | | | | | | | | | |
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| Type of Placement:  Court Order  Social Service  Voluntary  Other: *A copy of the hold and placement agreement will be required upon placement.* | | | | | | | | | | | | | | | | |
| FAMILY INFO: | Adoptive/ Bio/Step | | | Mailing Address | | | | Date of Birth | | | Parent Email Address | | | | | |
| Father |  | | |  | | | |  | |  |  | | | | | |
| Full Name:       Home Phone:       Cell Phone: | | | | | | | | | | | | | | | | |
| Mother |  | | |  | | | |  | |  |  | | | | | |
| Full Name:       Home Phone:       Cell Phone:  **Identify Physical and Legal Custody of the Child:**  **NAME AND CONTACT INFORMATION**: AGE: | | | | | | | | | | | | | | | | |
| Siblings | M  F | |  |  | | | |  | |  | Limits to contact | | | | | |
|  | M  F | |  |  | | | |  | |  | Limits to contact | | | | | |
|  | M  F | |  |  | | | |  | | | Limits to contact | | | | | |
|  | M  F | |  |  | | | |  | | | Limits to contact | | | | | |
| **Are there any restrictions on either parent’s involvement?** If so, please indicate here: | | | | | | | | | | | | | | | | |
| Please describe why you are making this referral, describe the treatment goals of placement, and what is the permanency/ post placement plan: | | | | | | | | | | | | | | | | |

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| History of Services Delivered: | | | | | | | | | | | | | | | | | | |
| Outpatient Services (therapy, day treatment, partial hospitalization): | | | | | | | | | | | | | | | | | | |
| Name of Agency: | | | Dates of Service: | | | | | | | Result: | | | | | | | | |
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| Residential/Inpatient Services (including hospitalizations): | | | | | | | | | | | | | | | | | | |
| Name of Agency: | | | Dates of Service: | | | | | | | Result: | | | | | | | | |
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| **Has youth received previous services from NHCFS in either Bemidji or Duluth locations? If yes, indicate below.**  Yes  No | | | | | | | | | | | | | | | | | | |
| Delinquency History:  Yes  NoYouth’s Previous Offenses | | | | | | | | | | | | | | | | | | |
| Year | | | Offense (also explain the original charges if you are on probation) | | | | | | | Outcome | | | | | | | | |
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| List your prescribed medications and over-the-counter drugs, such as vitamins and inhalers | | | | | | | | | | | | | | | | | | |
| Name of Current Pharmacy: | | | | | Pharmacy Phone Number: | | | | | | | | | | | | | |
| Name of Medication: | | | | | Strength / Mg | | Frequency Taken | Name of Current Prescriber & Clinic Associated With: | | | | | | | | | | |
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| Allergies | | | | | | | | | | | | | | | | | | |
| To | | | | | Reaction Had | | | | | | | | | | | | | |
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| History | | | | | | | | | | | | | | | | | | |
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| All questions contained in this questionnaire will be kept strictly confidential. | | | | | | | | | | | | | | | | | | |
| Abuse History | | Neglect Perpetrator(s): | | | | | | | | | | | | | | | | |
| Physical Perpetrator(s): | | | | | | | | | | | | | | | | |
| Emotional/Psychological Perpetrator(s): | | | | | | | | | | | | | | | | |
| Sexual Perpetrator(s): | | | | | | | | | | | | | | | | |
| Risk of Harm to Self | | Is there a history of cutting or self injurious behavior (SIB)? | | | | | | | | | | |  | | Yes | |  | No |
| Is there a history of suicidal ideation? | | | | | | | | | | |  | | Yes | |  | No |
| # of suicide attempts? | | | | | | | | | | | | | | | | |
| FASD | | None | | Suspected | | Has Diagnosis | | | | | |
| If diagnosed, name of Diagnostic Clinic/Professional? | | | | | | | | | | | | | | | | |
| Risk of Harm to Others | | History of Sexual Behaviors or Talk? | | | | | | | | | | |  | | Yes | |  | No |
| If yes, please describe? | | | | | | | | | | | | | | | | |
| Has the youth successfully completed treatment to address the behaviors/talk? | | | | | | | | | | | | | | | | |
| History of cruelty to animals? | | | | | | | | | | |  | | Yes | |  | No |
| Verbally abusive to others? | | | | | | | | | | |  | | Yes | |  | No |
| Physically abusive to others? | | | | | | | | | | |  | | Yes | |  | No |
| Gang involvement? | | | | | | | | | | |  | | Yes | |  | No |
| Difficulties with peer relationships? | | | | | | | | | | |  | | Yes | |  | No |
| Run Risk | | History of running away? | | | | | | | | | | |  | | Yes | |  | No |
| Recent – time gone: | | | | months ago: | | | years ago: | |
| Places youth goes: | | | | | | | | |
| Homelessness | | Does the youth have a history of being homeless? | | | | | | | | | | |  | | Yes | |  | No |
| Drugs / Alcohol | | Does youth currently use recreational or street drugs? | | | | | | | | | | |  | | Yes | |  | No |
| Does youth currently use alcohol? | | | | | | | | | | |  | | Yes | |  | No |
| Mental Health | | Does the youth have an eating disorder or suspected eating disorder? | | | | | | | | | | |  | | Yes | |  | No |
| Does the youth have grief or loss suffering? | | | | | | | | | | |  | | Yes | |  | No |
| If so, describe loss and month/season it occurred: | | | | | | | | | | | | | | | | |
| Does the youth have difficulty with parental relationships? | | | | | | | | | | |  | | Yes | |  | No |
| Additional Questions | | Lying or Cheating concerns? | | | | | | | | | | |  | | Yes | |  | No |
| Enuresis or Encopresis history/current concern? | | | | | | | | | | |  | | Yes | |  | No |
| Does the youth have vision or hearing loss? | | | | | | | | | | |  | | Yes | |  | No |
| Does the youth have history of gang involvement? | | | | | | | | | | |  | | Yes | |  | No |
| Is there a history or concern of truancy or lack of academic motivation? | | | | | | | | | | |  | | Yes | |  | No |
| Does the youth have identity issues? | | | | | | | | | | |  | | Yes | |  | No |
|  | | Does the youth have a history of Sexual Exploitation? | | | | | | | | | | |  | | Yes | |  | No |
|  | | | | | | | | | | | | | | | | | |
| Is there a current diagnostic/functional assessment?  Yes  No Date:       Provider/ Agency: | | | | | | | | | | | | | | | | | |
| Current School Attending: Is youth on an IEP?  Yes  No  Grade: | | | | | | | | | | | | | | | | | |
| Strengths of youth/family: | | | | | | | | | | | | | | | | | |
| Physical restrictions for the youth:    Yes  No  The developmental, educational, cultural, and mental health needs can be met by the program:  Yes  No | | | | | | | | | | | | | | | | | |
| Primary Physician– Please provide Name of Clinic, Physician, Dentist and Phone#:  Primary Dentist- | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **INSURANCE INFORMATION - A Copy of Insurance card is required** | | | | | | | | | | | | | | | | | |
| Name of Primary Insurance: | | | | | | | | | | | | | | | | | |
| **Is this a PMAP?** | | | | | | | | | | | | |  | | Yes |  | No |
| **Has the placement been approved by the PMAP?** | | | | | | | | | | | | |  | | Yes |  | No |
| **Have you requested a faxed confirmation?** | | | | | | | | | | | | |  | | Yes |  | 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?** | | | | | | | | | | | | |  | | Yes |  | 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: | | | | | | | | | | | | | | | | | |

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|  | | Requested additional service |
|  | | Additional services requested. Specific information can be added in the space provided. |
|  | Psychological Evaluation: | |
|  | Individual Therapy: | |
|  | Family Therapy: | |
|  | Rule 25 and/assessment: | |
|  | Religious / Cultural Needs: | |
|  | Medication Management: | |
|  | Specific Medical/ Dental Care: | |
|  | Other: | |