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.

For Boys Program, TNT, or Next step please email to suzette.mallum@northhomes.org

Youth Name *(First, Middle, Last)*	Identifies as ☐ M ☐ F **Pronouns:**	**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:			

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**

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:

History of Services Delivered:		
Outpatient Services (therapy, day treatment, partial hospitalization):		
Name of Agency:	Dates of Service:	Result:
Residential/Inpatient Services (including hospitalizations):		
Name of Agency:	Dates of Service:	Result:
Has youth received previous services from NHCFS in either Bemidji or Duluth locations? If yes, indicate below. ☐ Yes ☐ No		
Delinquency History**:** ☐ **Yes** ☐ **No** **Youth's Previous Offenses**		
Year	Offense (also explain the original charges if you are on probation)	Outcome

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:

Allergies	
To	Reaction Had

HISTORY

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:		

	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: