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| NH logo small.jpg | | | | | | | | | | | | | | | | | 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 (First, Middle, Last) | | |  | | | | | | | | | M  F | | | DOB: | | | **Age:** | | | |
| Type of Referral: | 35 Day Evaluation  Stabilization/90 Day Intensive Treatment  Secure Detention  Professional Foster Care  Residential Treatment Cottage or Girls residential treatment  Boys Program  Boys Teens In Transition  SEY program | | | | | | | | | | | | | | | | | | | | |
| Youth S.S. Number: | | | | | | | |  | Race:       If applicable, Tribe: | | | | | | | | | | |  | |
| Youth’s Current Residence: | | | | | | | | | | | | | | | | | | | | | |
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| Information | | | | | | | | | | | | | | | | | | | | | |
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| Referral Source Name: | | | | |  | | | | | | | | | | | | | | | |
| Title: | | | | SW | | | County | | | CMH | | | | | | County | | | | | |
|  | | | | PO | | | County | | | Parent | | | | | | Custody Type | | | | | |
|  | | | | TW | | | Tribe | | | 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 | | | | | | | |
| Full Name:       Home Phone:       Cell Phone:       TPR:  Yes  No  In Process | | | | | | | | | | | | | | | | | | | | | |
| Mother |  | | | | |  | | | | |  | |  | Has Custody | | | | | | | |
| Full Name:       Home Phone:       Cell Phone:       TPR:  Yes  No  In Process | | | | | | | | | | | | | | | | | | | | | |
| 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: | | | | | | | | | | | | | | | | | | | | | |
| Referral Source Narrative: | | | | | | | | | | | | | | | | | | | | | |

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| Youth’s Previous Placements | | | | | | | | | | | | | | | | | |
| Year | | Reason | | | | | | | | Agency / Location | | | | | | | |
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|  | |  | | | | | | | |  | | | | | | | |
| **Has youth received previous services from NHCFS in either Bemidji or Duluth locations? If yes, indicate below.**  Yes  No | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | |  | | | | | | | |
| Youth’s Previous Offenses | | | | | | | | | | | | | | | | | |
| Year | | Offense (also explain the original charges if you are on probation) | | | | | | | | Outcome | | | | | | | |
|  | |  | | | | | | | |  | | | | | | | |
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| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | | | | | | | | | | | | | | | | |
| Name of Current Pharmacy: | | | | | Pharmacy Phone Number: | | | | | | | | | | | | |
| Name of Drug | | | | | Strength / Mg | | Frequency Taken | Name of Prescriber & Clinic Associated With | | | | | | | | | |
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| Allergies | | | | | | | | | | | | | | | | | |
| To | | | | | Reaction Had | | | | | | | | | | | | |
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| 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? | | | | | | | | | | | | | | |
| Current risk of suicide | Hi | | Med | | | Low | | | | | | | | |
| FASD | | | None | Suspected | | Requesting Diagnosis | | | 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: | | N/A: | | | | | | |
| # of runs: | 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 |
|  | | | | | | | | | | | | | | | | |
| Is there a current diagnostic/functional assessment?  Yes  No Date:       Clinic/Doctor: | | | | | | | | | | | | | | | | |
| Specific goals for the youth to accomplish:       Is youth on an IEP?  Yes  No  Last School Attended:       Grade: | | | | | | | | | | | | | | | | |
| Strengths of youth/family: | | | | | | | | | | | | | | | | |
| Physical restrictions for the youth:  The developmental, educational, cultural, and mental health needs can be met by the program:  Yes  No | | | | | | | | | | | | | | | | |
| Primary Physician and Dentist – Please provide Name of Clinic, Physician, Dentist and Phone#: | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **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 Diagnostic: |  | Family Assessment: |  | Medication Management: |
|  | Psychiatric Diagnostic: |  | Individual Therapy: |  | Specific Medical/Dental Care: |
|  | Rule 25 and/or CD Care: |  | Family Therapy: |  | Other: |
|  | CTSS/MHBA: |  | Adoption Services: |  | Religious / Cultural Needs: |
|  | Free at Last / Evergreen: |  | Community Service Hours: |  | Driver’s Training: |