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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:       |
|  |
| Information |
|  |
| 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 |
|       |       |       |
|       |       |       |
|       |       |       |
| **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 |
|       |       |       |
|       |       |       |
| 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 |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| 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?       |
| 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:       |