NORTH HOMES
Children and Family Services

Today's Date:

Youth Name *(First, Middle, Last)*	Identifies as **Pronouns:** ☐ M ☐ F	**DOB:**	**Age:**
Type of Referral: ☐ 35 Day Evaluation ☐ Shelter ☐ SEY Transition Living ☐ Crisis Stabilization ☐ Residential Treatment ☐ Transitional Living ☐ Group Home			
Youth S.S. Number:	**Race:**	If applicable, **Tribe:**	
Youth's Current Placement:			

INFORMATION

Referring Agency:	**Worker's Name**	**Phone/ Email:**	**County:**
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
Parent				
Full Name:		Home Phone:	Cell Phone:	
Parent				
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:

What is the child's IQ?

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:
☐	Substance Use Assessment:
☐	Religious / Cultural Needs:
☐	Medication Management:
☐	Diagnostic Assessment:
☐	Other:

Please return his form with the following documentation:

- Most recent Diagnostic Assessment
- Psychological and Neuropsychological Evaluation (Most recent if more than one)
- Psychiatric Evaluation (Most recent if more than one)
- Discharge Summaries from previous placements
- Progress Reports from current placements
- Individual Education Plan
- Most recent school evaluation
- CASII