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| **RESIDENT INFORMATION** |
| **Child’s Full Name:** | **Male:** **[ ]**  **Female:** **[ ]**  | **Today’s Date:**       |
| Ethnicity:      | Language:      | Religion:      | DOB:       | Age:       |
| Current Placement/Address:       |
| Physical Description:       Ht:       Wt:        | Discharge Plan (Return home, Foster Care):       |

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| **BIOLOGICAL Mother’s Information** | **BIOLOGICAL Father’s Information** |
| Name:       | Name:       |
| Address:       | Address:       |
| Phone:       | Cell:       | Phone:       | Cell:       |
| E-Mail:       | E-Mail:       |
| Place of Employment:       | Place of Employment:       |
| Is parent Legal Guardian: Yes: **[ ]** No: **[ ]** Parental Rights Terminated: Yes: **[ ]** No: **[ ]** Is child adopted: Yes: **[ ]** No: **[ ]** Is parent involved: Yes: **[ ]** No: **[ ]** Comments:       | Is parent Legal Guardian: Yes: **[ ]** No: **[ ]** Parental Rights Terminated: Yes: **[ ]** No: **[ ]** Is child adopted: Yes: **[ ]** No: **[ ]** Is parent involved: Yes: **[ ]** No: **[ ]** Comments:       |

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| **LEGAL GUARDIAN INFORMATION – *If other than Parent*** |
| Name/Relationship:        | Phone:       |
| Agency:       | Cell:       |
| Address:       | E-Mail:       |
| **REFERRAL SOURCE INFORMATION** |
| Referral Source: [ ]  School Parent: **[ ]** Agency/County: [ ]  Other:       |
| County of Referral:       |
| Name/Agency of Referral Source:       |
| Name/Title (Case Manager, ICC Coordinator, etc.):       |
| Address:       |
| Phone:       | Cell:       | Fax:       | E-Mail:       |
| **FUNDING** |
| ***Childhelp will not be responsible for payment of medication costs,*** ***or any medical appointments/procedures that are not covered by*** ***Medicaid or private insurance.******RESPONSIBLE PARTY for Co-Pays & unpaid Medical Bills:***       |
| Medicaid: [ ]  | Title-IV-E: [ ]  | CSA: [ ]  | Adoption Subsidy: [ ]  | HMO:**[ ]**  | Private Insurance: **[ ]**  |
| **Medicaid Insurance #:**  | **Social Security #:**       |
| Private Insurance Company:       | Private Insurance Member #:       |
| Private Ins. Member’s Name:       | DOB:       | Private Ins. Phone #:       |
| **FOR VIRGINIA REFERRALS** **I agree to participate in the IACCT Process****Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **FUNDING/PLACING AGENCY**  |
| Placing Agency/County that is **Funding** Placement:        |
| Address:       | Phone:      | Fax:      |
| CSA Coordinator:       | E-Mail:       |

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| **OTHER INVOLVEMENT *(Step-Parent, Foster Parent, GAL, CASA Worker, etc.)*** |
| Name/Relationship:       | Phone:       |
| Address:       | Fax:       |
| Name/Relationship:       | Phone:       |
| Address:       | Fax:       |

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| **MENTAL HEALTH INFORMATION** |
| Reason for Referral:       |
| Abuse History: Physical [ ]  |  Sexual [ ]  |  Emotional [ ]  | Neglect [ ]  |  Trauma [ ]  |
| Clinical Assessments Requested:       |
| **EDUCATIONAL INFORMATION** |
| Current Grade:       | Local Ed. Agency (LEA):       | IEP: Yes [ ]  No [ ]  |
| Related Services (OT, Speech, etc.,):       |
| Current School:       | Contact Person:       |
| Address:       | Phone:       | Fax:       |
| **CHILD and FAMILY INFORMATION** |
| Legal Involvement:Yes [ ]  No: [ ]  | If “yes”, explain:       |
| Parole Officer:       | Address:       | Phone:       |
| Protective Order in Place: Yes [ ]  No: [ ]  | If “yes”, explain:       |
| Is there Restrictive Contact: Yes [ ]  No: [ ]  | If “yes”, explain:       |
| Does family have reliable transportation to attend Therapy/Treatment/Meetings: Yes [ ]  No: [ ]  |
| **HEALTH and NUTRITION INFORMATION** |
| ***Childhelp reserves the right to*** ***not admit a child who presents with a communicable disease at the time of admission,******unless our Medical Director certifies that our facility is capable of*** ***providing care to the child, without jeopardizing residents and staff.******Please advise the Admissions Department of any Communicable Disease -******(i.e., Flu, Strep, MRSA, Lice, HIV, Hep A, B, or C, etc.) that your child may have prior to admission.*** |
| Current Immunizations: Yes [ ]  No: [ ]   | Orthodontic Braces: Yes [ ]  No: [ ]  | Eye Glasses: Yes [ ]  No: [ ]  |
| Diagnosed Allergies-including drug/food intolerance:       |
| Any noted Nutritional Problems:       |
| Doctor ordered Therapeutic Diet: Yes [ ]  No: [ ]  |
| **CURRENT PHYSICIAN INFORMATION** |
| Doctor Name:       | Phone:       | Fax:       |
| Address:       | Last Appt:       |
|  |  |  |
| Dentist Name:       | Phone:       | Fax:       |
| Address:       | Last Appt:       |
|  |
| Other Specialist Name:       | Phone:       | Fax:       |
| Address:       | Last Appt:       |
| **DEVELOPMENTAL HISTORY** |
| Please indicate if there were any concerns with the following: |
| Child born at       months | Child toilet trained at      months |
| Normal delivery: Yes [ ]  No: [ ]   | If “no”, explain:       |
| Complications at birth: Yes [ ]  No: [ ]   | If “yes”, explain:       |
| Concerns with Gross Motor Skills: Yes [ ]  No: [ ]  | If “yes”, explain:       |
| Concerns with Fine Motor Skills: Yes [ ]  No: [ ]  | If “yes”, explain:       |
| Concerns with Speech Development: Yes [ ]  No: [ ]  | If “yes”, explain:       |
| **OTHER INFORMATION** |
| Likes:       | Dislikes:       |
| Indicators of success at Home/Other placements:       |
| History of Unsubstantiated Claims: Yes [ ]  No: [ ]  | If “yes”, explain:       |

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| **SIGNIFICANT BEHAVIOR INFORMATION** |
| Place an X next to behaviors that are occurringIndicate frequency with “Daily”, 4-5 days/wk, 1-2 days/wk, etc. |
| **BEHAVIOR** |  |  **FREQUENCY** |  |  **BEHAVIOR** |  |  **FREQUENCY** |
| Sexually Inappropriate | [ ]  |        |  |  Poor Hygiene | [ ]  |        |
| Homicidal Ideation | [ ]  |        |  |  Fire Setting | [ ]  |        |
| Suicidal Ideation | [ ]  |        |  |  Self-Harming Behaviors | [ ]  |        |
| Temper Outbursts | [ ]  |        |  |  Animal Cruelty | [ ]  |        |
| Physical Aggression | [ ]  |        |  |  Lying | [ ]  |        |
| Verbal Aggression | [ ]  |        |  |  Property Destruction | [ ]  |        |
| Stealing | [ ]  |        |  |  Runs Away | [ ]  |        |
| Enuresis | [ ]  |        |  |  Wanders at Night | [ ]  |        |
| Encopresis | [ ]  |        |  |  Depressed/Anxious Symptoms | [ ]  |        |
| Nightmares | [ ]  |        |  |  Oppositional Defiant Behaviors | [ ]  |        |
| **TREATMENT SERVICES and PLACEMENT HISTORY over PAST YEAR** |
| **Name of Service/Placement** | **Type of Service/Placement** | **Dates of Service****(mm/dd/yy)** | **Reason for Removal** |
|       |        |        |        |
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| **MEDICATION RECONCILIATION FORM** |

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| **Current Medication Name** | **Dosage** | **Schedule** |
|       |       |       |
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|  **MEDICATIONS TRIED in the PAST and their EFECTS** |  |
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| **Name of Person Providing Information:**       | **Date:**       |
| **Relationship:**       | **Phone:**       |