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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: | | | | | |
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| Dentist Name: | | | | | | | | | | | Phone: | | | | Fax: | |
| Address: | | | | | | | | | | | Last Appt: | | | | | |
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| 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 occurring  Indicate 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:** |