Revised 9/24/2020

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| **RESIDENT INFORMATION** | | | | | | | |
| **Child’s Full Name:** | | | **Male:**  **Female:** | | | **Today’s Date:** | |
| Ethnicity: | Language: | Religion: | | | DOB: | | Age: |
| Current Placement: Home Acute Facility Foster Care Other:  Address: | | | | | | | |
| Physical Description: | | | | Discharge Plan:Return home Foster Care  Adoption Other: | | | |
| Ht:       Wt: | | | |

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| **BIOLOIGCAL PARENT’S INFORMATION**  NO KNOWN INFORMATION | | | |
| **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 bio-parent Legal Guardian: Yes: No:  Parental Rights Terminated: Yes: No:  Is parent involved: Yes: No:  Comments: | | Is bio-parent Legal Guardian: Yes: No:  Parental Rights Terminated: Yes: No:  Is parent involved: Yes: No:  Comments: | |

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| **LEGAL GUARDIAN INFORMATION – *If NOT Biological Parent*** | | |
| Name: | | Phone: |
| Relationship:  DSS Guardian Adoptive Parent Family member Legal Guardian Other: | | |
| Agency: | | Cell: |
| Address: | E-Mail: | |
| When did the child come into your care? | | |
| Is the child adopted? Yes: No: | | |
| If adopted, When was the child’s adoption finalized? | | |

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| **REFERRAL SOURCE INFORMATION** | | | |
| Referral Source: School Parent/Legal Guardian Agency/County Other: | | | |
| County of Referral: | | | |
| Agency of Referral Source: | | | |
| Name and Title (Case Manager, ICC Coordinator, etc.): | | | |
| Address: | | | |
| Phone: | Cell: | Fax: | E-Mail: |

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| **INSURANCE & 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.***  ***IDENTIFY RESPONSIBLE PARTY for Co-Pays & unpaid Medical Bills:*** | | | | | | | | |
| Medicaid: | Title-IV-E: | CSA: | Adoption  Subsidy: | | HMO: | | Private Insurance: | Tricare: |
| Medicaid Insurance #: | | | | Social Security #: | | | | |
| Tricare Insurance ID: | | | | Tricare Phone #: | | | | |
| Private Insurance Company: | | | | Private Insurance Member #: | | | | |
| Private Insurance Member’s Name: | | | | DOB: | | Private Ins. Phone #: | | |

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| **FOR VIRGINIA REFERRALS** | | |
| **I agree to participate in the IACCT Process**  **Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **IACCT assessment:**  Started Completed recommending RTF | | |
| Placing Agency/County that is **Funding** Placement/Education: | | |
| 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: Long Term Placement Assessment and Diagnostic | | | | |
| Abuse History: Physical | Sexual | Emotional | Neglect | Trauma |
| Comments regarding abuse history: | | | | |
| Current Mental Health Diagnosis: | | | | |
| Clinical Assessments Requested: | | | | |

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| **EDUCATIONAL INFORMATION** | | | | |
| Current Grade: | Local Ed. Agency (LEA): | | IEP: Yes No | |
| FSIQ:       ( Never Tested) | Child is ( on below above) grade level | | | |
| Related Services (OT, Speech, etc.,): | | | | |
| Current School: | | Contact Person: | | |
| Address: | | Phone: | | Fax: |

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| **CHILD and FAMILY INFORMATION** | | |
| Legal Involvement: Yes No: | Child Parent If “yes”, explain: | |
| Probation/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: | | |

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| **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: | | |
| Diagnosed Medical issues: | | |
| Any noted Nutritional Problems: | | |
| Doctor ordered Therapeutic Diet: Yes No: | | |

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| **CURRENT PHYSICIAN INFORMATION** | | |
| Primary Care Physician Name: | Phone: | Fax: |
| Address: | Last Appt: | |
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| Psychiatrist 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: | |

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| **DEVELOPMENTAL HISTORY**  NO KNOWN INFORMATION | |
| 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: |

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| **OTHER INFORMATION** | | |
| Likes: | | Dislikes: |
| Strengths: | | |
| Indicators of success at Home/Other placements: | | |
| History of Unsubstantiated Claims: Yes No: | If “yes”, explain: | |
| History of Substance use: Yes No: | Child Parent 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 |  |  |

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| **PAST PLACEMENTS (Provide for up to the last year)** | | | |
| **Name of Placement** | **Type of Service/Placement**  (i.e. Acute Hospital, Foster care, Residential, etc.) | **Dates of Service**  (mm/dd/yy – mm/dd/yy) | **Reason for Removal/Discharge** |
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| **PAST SERVICES (Provide for up to the last year)** | | | |
| **Name of Agency** | **Type of Service**  (i.e. Psychiatric, Outpatient, Family Therapy, Play Therapy, etc.) | **Dates of Service**  (mm/dd/yy – mm/dd/yy) | **Reason for Discharge** |
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| **MEDICATION RECONCILIATION FORM** | | |
| **Current Medication Name** | **Dosage** | **Schedule** |
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| **MEDICATIONS TRIED in the PAST and their EFECTS** | | |
| **Medication Name** | **Effects** | |
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| **For referrals to be considered by the admissions team the following documentation will need to be reviewed:** | | |
| Most recent Medical Physical | Attached | Never had one |
| Most recent Grades | Attached | Never attended school |
| Most recent behavior reports (school) | Attached | Never attended school |
| Psychiatric evaluation | Attached | Never had one |
| Psychological evaluation | Attached | Never had one |
| Assessments and Daily progress notes from previous placements | Attached | Never had one |

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| **Name of Person Providing Information:** | **Date:** |
| **Relationship:** | **Phone:** |