PSYCHIATRIC RESIDENTIAL TREAMENT FACILITY
ADMISSION APPLICATION

Date of Referral:_____

CONSUMER INFORMATION

Consumer's Name:_____
(first) (middle) (last)
Preferred Name: _____

Social Security Number: _____ Date of Birth:_____

Age: _____ Sex:_____ Race _____

Medicaid Number:_____ County: _____

Weight:_____ Height:_____

Consumer's Current Address:

_____

_____

Consumer's Phone Number: _____

Current Living Arrangement _____

Place of Birth: _____

Primary Language_____

Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.):

_____

CONSUMER INFORMATION

CURRENT PLACEMENT (if consumer is out of the home)

AGENCY:_____

ADDRESS: _____

_____

POINT OF CONTACT:

_____

PHONE: (___)_____ **FAX:** (___)_____

LENGTH OF STAY:

_____

REASON FOR LEAVING:

_____

_____

HAS CONSUMER RECEIVED RESTRICTIVE INTERVENTION(S) IN LAST 30 DAYS:

☐ **YES HOW MANY?** _____

☐ **NO**

PREFERRED FACILITY

☐ **Hope Gardens Treatment Center** ☐ **New Haven Treatment Center**

☐ **Cornerstone Treatment Facility** ☐ **Crossroads Treatment Center**

☐ **Gracehouse Treatment Center** ☐ **Willowbrook Treatment Center**

☐ **Jackson Springs Treatment Center**

☐ **No Preference**

GUARDIAN INFORMATION

BIOLOGICAL MOTHER'S NAME:

_____

(first) (middle) (last)

ADDRESS: _____

_____

Home: (___)_____
Work: (___)_____
Other: (___)_____

BIOLOGICAL FATHER'S NAME:

_____

(first) (middle) (last)

ADDRESS: _____

_____

Home: (___)_____
Work: (___)_____
Other: (___)_____

IF PARENTS ARE DIVORCED/UNMARRIED, WHAT IS CUSTODY ARRANGEMENT (provide documentation)?

_____

HAVE PARENTAL RIGHTS BEEN TERMINATED? ☐ YES ☐ NO
IF YES, WHEN? _____

HAS CLIENT BEEN ADOPTED? ☐ YES ☐ NO
IF YES, DATE OF FINAL ADOPTION ORDER:_____

GUARDIAN INFORMATION

Legal Guardian: _____
(first) (middle) (last)

Relationship: _____

County of Legal Custody: _____

Legal Guardian's Address: _____

_____

Legal Guardian's Phone Number:

Home: (___)_____

Work: (___)_____

Other: (___)_____

REFERRAL SOURCE INFORMATION

REFERRING AGENCY:

☐ Community Support ☐ DJJ ☐ DSS ☐ Other ☐

COUNTY: _____

AGENCY:_____

ADDRESS: _____

_____

REFERRAL NAME: _____

PHONE: (___)_____

FAX: (___)_____

EMAIL:_____

CLINICAL INFORMATION

	DIAGNOSIS CODE	DIAGNOSIS
AXIS I	**1. _____** **2. _____** **3. _____** **4. _____**	**1. _____** **2. _____** **3. _____** **4. _____**
AXIS II	**1. _____** **2. _____**	**1. _____** **2. _____**
AXIS III	**1. _____** **2. _____**	
AXIS IV	**1. _____** **2. _____** **3. _____** **4. _____**	
AXIS V	**GAF: _____**	

Clinician: _____
Date of Diagnosis: _____

Has consumer received psychological evaluation: ☐ YES ☐ NO
If yes, please note results:

IQ: _____ Verbal _____ Performance_____ Full Scale _____

Clinician: _____
Date: _____

History of Abuse: ☐ Victim of Neglect ☐ Victim of Physical Abuse

☐ Victim of Sexual Abuse ☐ Victim of Emotional Abuse

☐ None

If yes, please explain:

_____

_____

DSS involvement, if yes please attach documentation? ☐ YES ☐ NO

CLINICAL INFORMATION

PRESENTING CONCERNS/REASON FOR REFERRAL:

_____
_____
_____
_____
_____
_____
_____

CURRENT MEDICATION				
MEDICATIONS	**DOSAGE**	**FREQUENCY**	**DATE STARTED**	**COMPLIANT Y/N**

Prescribing Physician: _____

TREATMENT HISTORY (e.g., Residential, Hospitalizations, MST, etc.)				
DATE	**SERVICE**	**LENGTH OF SERVICE**	**EFFECTIVE Y/N**	**COMPLIANT Y/N**

CLINICAL INFORMATION

Check all that apply (include date of behaviors):

- ☐**Abandonment Issues**
- ☐**Anxiety**
- ☐**Arson**
- ☐**Alcohol/Drug Abuse**
- ☐**Antisocial Behavior**
- ☐**Difficulty With Authority**
- ☐**Assault (Physical)**
- ☐**Assault (Sexual)**
- ☐**Assault (Verbal)**
- ☐**Difficulty with following rules**
- ☐**Difficulty with accepting responsibility**
- ☐**Destroying Property**
- ☐**Difficulty with accepting consequences**
- ☐**Self Destructive Behavior**
- ☐**Bedwetting**
- ☐**Stool/Feces smearing**
- ☐**Eating Disorder**
- ☐**Depression**
- ☐**Oppositional**
- ☐**Fire Setter**
- ☐**Cruelty to Animals**
- ☐**Gang Related Activity**
- ☐**Homeless**
- ☐**Hyperactive**
- ☐**Impulsive**
- ☐**Lying**
- ☐**Low Self-Esteem**
- ☐**Loss/Grief**
- ☐**Physical Impairment**
- ☐**Developmental Disability**
- ☐**Physical Disability**
- ☐**Mental Retardation**
- ☐**Perception of Reality**
- ☐**Phobic Behavior**
- ☐**Sibling Related Difficulty**
- ☐**Social Immaturity**
- ☐**Sexually Inappropriate Behavior**
- ☐**Stealing**
- ☐**Suicidal**
- ☐**Running Away**
- ☐**Truancy**
- ☐**Unruly/Ungovernable**
- ☐**Poor Hygiene**
- ☐**Problems with Sleep**
- ☐**History w/ Weapons**
- ☐**Other:**

CLINICAL INFORMATION

RISK ASSESSMENT

Risk to Self (Suicide):

Suicidal Ideation ☐ **YES,** **Dates:** _____

☐ **NO**

Suicidal Plans ☐ **YES** **Describe:** _____

_____

_____

☐ **NO**

Suicidal Attempts ☐ **YES** **Dates:** _____

☐ **NO**

Describe method: _____

_____

_____

Risk to Others (Homicide):

Homicidal Ideation ☐ **YES,** **Dates:** _____

☐ **NO**

Homicidal Plans ☐ **YES** **Describe:** _____

_____

_____

☐ **NO**

Homicidal Attempts ☐ **YES** **Dates:** _____

☐ **NO**

Describe method: _____

_____

_____

Has consumer made any attempts to run from home/placement? ☐ **YES** ☐ **NO**
If so, how many attempts in past year? _____

CLINICAL INFORMATION				
SUBSTANCE USE HISTORY				
SUBSTANCE	**LAST USE**	**FREQUENCY**	**AMOUNT**	**METHOD**
☐**Alcohol**				
☐**Marijuana**				
☐**Amphetamines**				
☐**Hallucinogens**				
☐**Cocaine**				
☐**Heroin/Opiates**				
☐**Inhalants**				
☐**Other:**				

HISTORY OF SEXUALIZED BEHAVIORS

Has consumer displayed any sexual aggression towards others? ☐ YES ☐ NO

Has consumer been adjudicated for sexual offense? ☐ YES ☐ NO
(provide documentation)

Is the consumer on the North Carolina sex offender registry? ☐ YES ☐ NO

Describe sexualized behaviors.

_____
_____
_____
_____
_____

CRIMINAL HISTORY

Does Consumer have a criminal record? ☐ YES ☐ NO
Pending Charges: _____

Is placement court ordered? ☐ YES ☐ NO (If "Yes, attach court order)

Is Consumer on Probation? ☐ YES ☐ NO
Court Counselor Name: _____
Work: (___)_____
Fax: (___)_____

PSYCHOTIC BEHAVIORS

Describe past or current history of psychosis.

_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

Please check all that apply:

☐ **Lice**	☐ **Bulimia**
☐ **Eczema**	☐ **Anemia**
☐ **Anorexia**	☐ **Asthma**
☐ **Drug/Alcohol Abuse**	☐ **Measles**
☐ **Hay Fever**	☐ **HIV/AIDS**
☐ **Mumps**	☐ **Convulsions**
☐ **Sexually Transmitted Disease**	☐ **Chicken Pox**
☐ **Sinus Problems**	☐ **Ringworm**
☐ **Sickle Cell Anemia**	☐ **Diabetes**
☐ **Tuberculosis**	☐ **Migraine Headaches**
☐ **Hepatitis**	☐ **Chronic Urinary/Bowel Problems**
☐ **Rubella**	☐ **Traumatic Brain Injury**

☐ **Allergies:_____**

☐ **Dietary Needs:_____**

☐ **Other:_____**

MEDICAL HISTORY

Consumer Primary Care Physician:
Name: _____
Address: _____
_____
Office: (___)_____
Fax: (___)_____

Date of Last Physical Exam: _____

Date of Last Dental Exam: _____

Date of Last Eye Exam: _____

EDUCATIONAL HISTORY

Last School Enrolled: _____

Grade: _____

Regular Classes: ☐ YES ☐ NO

Exceptional Classes: ☐ YES ☐ NO
(Specify) _____

Does consumer have 504 plan or IEP? ☐ YES ☐ NO
(provide documentation)

Current IEP? Yes No Date: _____

Grades Repeated: ☐ YES What grade: _____

☐ NO

History of Suspensions/Expulsions, please explain:
_____
_____
_____
_____
_____

COMMUNITY SUPPORTS

Which of the following entities are involved with the consumer? (check all that apply)

☐ DSS ☐ Mental Health Provider ☐ DJJ ☐ Vocational Rehab

☐ Other: _____

FAMILY HISTORY

Does the consumer have siblings? ☐ YES ☐ NO

Siblings Name	Age	Gender	Current Location

Are siblings in out-of-home placements? ☐ YES ☐ NO
If yes, please specify: _____
_____
_____

Describe family's social history and/or any significant family events prior to referral.
_____
_____
_____
_____

What was the living arrangement prior to referral?
_____
_____
_____
_____

Does the family have a history of the following: (check all that apply)

☐ Criminal Activity **☐ Child Abuse**

☐ Inappropriate Sexual Behavior **☐ Treatment Disruption**

☐ Psychiatric Illness **☐ Substance Abuse**

☐ Suicide **☐ Other:_____**

Are there any special conditions/restrictions for visits home? ☐ YES ☐ NO
If yes, please explain: _____
_____

Any "no contact" orders? ☐ YES ☐ NO
If yes, please explain: _____
_____

Discharge Plan – Our programs prepare residents to live in less restrictive environments upon discharge. However, the problems of our residents are more severe than most. They continue to need intense services (though not in a locked facility) after they leave.

Anticipated Needs Upon Discharge: Can resident return to prior living arrangement?: ☐ Yes ☐ No, or ☐

Refer to local Mental Health / Developmental Disability / Substance Abuse Services with following recommendations:

☐ Individual Therapy	☐ Community Support Services	☐ Developmental Disability Services	☐ Medicaid
☐ Group Therapy	☐ Group Home Placement	☐ Multi-systemic Therapy (MST)	☐ Social Security / SSI
☐ Family Therapy	☐ Legal Services	☐ Psychiatric Residential Treatment Facility	☐ Medication Financial Assistance
☐ Case Management	☐ Supportive Employment	☐ Diagnostic Assessment	☐ Day Treatment
☐ Intensive In-Home Psychiatric Services	☐ Partial Hospitalization	☐ Child & Adolescent Day Treatment	☐ Needs Guardian
☐ Assertive Community Treatment Team (ACTT)	☐ Medication/Symptom Management	☐ Public School Education / Evaluation	☐ Self-Help Group / AA, etc.
☐ Mobile Crisis Management	☐ Outpatient Commitment	☐ Public Health/Home Health	☐ Speech, PT, OT Services
☐ Substance Abuse Treatment	☐ Leisure Activity	☐ 1:1 Mentor	☐ Weekly 1:1 Time with Parent / Guardian

Other Recommendations: _____

_____

For any recommended services, please list the name of the anticipated provider:

_____

_____

_____

Please note: All information must be completed before the application can be reviewed and processed by our Medical Director. In addition to the completed application, the following items must also be submitted to continue with considering the consumer for treatment at our facilities:

REQUIRED DOCUMENTS	COMPLETED
COMPLETED APPLICATION	
COMPLETED CERTIFICATE OF NEED (CON)	
CURRENT COMPREHENSIVE CLINICAL ASSESSMENT	
PERSON-CENTERED PLAN w/UPDATED SIGNATURES	
DISCHARGE SUMMARIES (Previous Treatment)	
CURRENT PSYCHOLOGICAL EVALUATION	
COURT and/or CUSTODY ORDERS, if applicable	
COPY OF MEDICAID/INSURANCE CARDS	
PSYCHIATRIC EVALUTIONS	
INPATIENT TREATMENT REPORT (ITR)	
SCHOOL RECORDS/IEP	
IMMUNIZATION RECORDS	
SSI, if applicable	
CURRENT PHYSICAL/DENTAL EXAM	