

Referral to Mary Hill Youth and Family Center (MHYFC)

PERSON FILLING OUT FORM: DATE:

Phone: EMAIL:

Youth’s First Name: Middle Name:

Youth’s Last Name: SOC SEC #:

DOB:

Race: (OPTIONAL)

Weight: Eye Color:

Age: Height: Hair Color: Gender: Gender Identity:

# IS YOUTH CURRENTLY USING SUBSTANCES IS YOUTH PREGNANT

Does youth have children: If so, please list names and ages:

# REFFERAL RECORD

**\*Attach copy of CANS assessment notating that residential level of care is indicated (CANS will be required within 30 days of admission if not initially available).**

Agency: Agency contact: Address: City: State: Zip:

Phone #:

# List youth’s current behaviors and treatment goals and why they are being referred for residential care:

PERMANENCY PLAN: (What natural supports does youth currently have in place, who will visit and call youth besides providers?)

PLACEMENT HISTORY

Youth’s current living arrangement:

Please list placements youth has experienced in the past 12 months:

# CUSTODY INFORMATION

Who has custody of youth:

Is there shared parenting: Relationship to youth: Address of custodian: City: State: Zip: Phone #:

# EMERGENCY CONTACTS

Emergency contact name: Phone number: Relationship to youth:

Emergency contact name:

Phone number: Relationship to youth:

**BIOLOGICAL PARENTS** (if applicable)

Mother’s name: Mother’s address: City: State: Zip: Phone number:

Father’s name: Father’s address: City: State: Zip: Phone number:

**ADOPTIVE/ FOSTER PARENTS** (if applicable)

Mother’s Name: Mother’s address: City: State: Zip: Phone number:

Father’s Name: Father’s address: City: State: Zip: Phone number:

# LEGAL INFORMATION

Does youth have legal involvement: Y or N

On probation: Y OR N Are charges pending : Y OR N Court ordered: Y OR N Consequences if treatment is not completed: Court name:

Court address: City: State: Zip: Phone number:

Probation office: Phone number:

Probation officer’s emergency contact number:

Previous misdemeanors: Previous felonies: Number of times in detention center:

# ABUSE INFORMATION

Sexually abused: Y OR N Age and sex of perpetrator: Briefly explain nature of abuse:

Has youth been charged in a sexual crime: Y OR N Explain: Physically abused: Y OR N Explain: Domestic violence: Y OR N Victim Perpetrator or Witness

Explain:

Has any of the above been reported: Y OR N If so to whom**:**

# MENTAL HEALTH INFORMATION

**Has youth attempted suicide: Y OR N**

Number of attempts: Date of most recent attempt: Attempt method: Did youth need medical care: Y OR N

Was youth admitted as an inpatient due to suicide attempt: Y OR N Is youth stable now: Y OR N Current suicide risk: Low Med High Does youth have a suicide plan: Y OR N

Has youth engaged in any type of self-harm: Y OR N

Nature of the harm: cutting burning breaking bones Other: Explain

When was the last incident:

# Has youth been diagnosed with a mental health disorder: Y OR N

List Diagnoses: Diagnosed by: Current mental health (psychotropic) medications:

# PAST OUTPATIENT MENTAL HEALTH TREATMENT

Number of past mental health services: \_ Last discharge date:

Name of program treated at most recently: Address: City: State: Zip: Phone number:

Provider of psychiatric/psychological services: Diagnosis:

# PAST INPATIENT MENTAL HEALTH TREATMENT

Number of past inpatient mental health services: Last Discharge date: Name of program treated at most recently: Address: City

State: Zip: Phone number:

Provider of psychiatric/psychological services: Diagnosis:

# VIOLENT BEHAVIOR RECORD

Does youth have a history of violent behavior: Y OR N If yes when was last episode:

If yes is behavior related to a mental health diagnosis: Y OR N

Type of violent behavior:

To Family: Y OR N Peers: Y OR N Strangers: Y OR N Animals: Y OR N Is youth an assault risk currently: Y OR N Is youth stable now: Y OR N History of starting fires: Y OR N

When Where

# SCHOOL INFORMATION

Does youth attend: Regular School Online School \_ Home School GED Other educational program: Do you give permission for youth to work towards a GED: Y OR N School name: School Address: City

State: Zip: Phone number: Principal/counselor’s name: Phone number: IEP Y OR N Special Education: Y OR N

*\*If youth has IEP please attach copy.*

Please list any learning disabilities: Suspensions: Y OR N Explain: Expulsions: Y OR N Explain:

# MEDICAL INFORMATION

Please list all medications youth is CURRENTLY taking:

Has youth ever overdosed: Y OR N Accidental: Y OR N

When and on What: Serious head injury: Y OR N Explain: List any serious/chronic medical issues: Seizures: Y OR N When was last episode: Dental Problems: Physical disabilities: Dietary restrictions: Food allergies: Allergies to medications:

Eating Disorders: Y OR N Anorexia: Y OR N Bulimia: Y OR N Is this current: Y OR N Is Youth medically stable: Y OR N

Birth control: Y OR N STD’S: Y OR N Diagnosis: Heart murmurs or heart conditions: Y OR N Describe: Immunizations up to date: Y OR N

\*A copy of a negative Tuberculosis (TB) Mantoux Skin Test will be required for admission.

# HOSPITAL/PHYSICIAN INFORMATION

Does youth have a primary care physician: Y OR N IF YES, Primary Care Physician’s Name: Address: City

State: Zip: Phone number:

IF NO, where does youth receive medical care:

Address: City State: Zip: Phone number:

Any major medical treatment within the last 24 months: Y OR N

Explain: Name of Hospital:

Address: City State: Zip: Phone number:

# THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY

**MEDICAID INFORMATION**

Does youth have Medicaid: Y OR N

If yes, Medicaid billing number: Name of county that issued the Medicaid: Name of Managed Care Provider: If youth does not have Medicaid and is eligible, who will apply?

**INSURANCE INFORMATION** (if applicable)

Name of primary insurance company:

Address: City: State: Zip: Phone number:

Pre-Authorization phone number:

Mental Health/substance abuse phone number:

Policy holder/subscriber:

Policy holder/subscriber’s address:

City State: Zip: Phone number:

Policy holder’s relationship to youth:

Group number: Plan Number: Name of employer:

Address: City

State: Zip: Phone number: Additional information:

Name of secondary insurance company: Address: City State: Zip: Phone number:

Pre-Authorization phone number:

Mental Health/substance abuse phone number:

Policy holder/subscriber:

Policy holder/subscriber: Address: City:

State: Zip: Phone number:

Policy holder’s relationship to youth:

Group number:

Plan Number: Name of employer:

Address: City

State: Zip: Phone number: Additional information: