Referral to Mary Hill Youth and Family Center (MHYFC)

Name of Person Filling Out Form:______________________________________ Date:_____________

Phone:_____________________ Email:____

Youth's First Name: _____________________________________Middle Name: _____________________

Youth's Last Name: ______________________________________SOC SEC #: ______________________

DOB:____ Age:__________________________

Race: (OPTIONAL)________________________________ Height:________________________

Weight:____ Hair Color: _____________________

Eye Color: ______________________________________ Gender: ________________________

Gender Identity: ________________

IS YOUTH CURRENTLY USING SUBSTANCES______ IS YOUTH PREGNANT_______

Does youth have children: ________If so, please list names and:_____________________________________

____

____

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?)

____

____

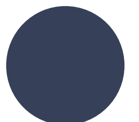
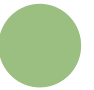
PLACEMENT HISTORY

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

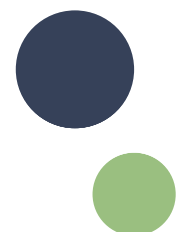
Type of violent behavior: ____

To Family: Y OR N Peers: Y OR N Strangers: Y OR N Is youth an assault risk currently: Y OR N

To Animals: 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: ______________