



YOUTH'S DEMOGRAPHICS

Youth's Name: _____ Date of Referral: _____
Date of Birth: _____ Religion: _____ Age: _____
Height: _____ Weight: _____ Race: _____
Youth's Current Placement: _____ Length of Stay in Current Placement: _____

PLACING AGENCY

Referral Agent Primary Contact: _____ Referral Agent Department: _____
Address: _____
Phone: _____ Fax: _____ Email: _____
Please indicate how you learned about Nexus: _____

FUNDING INFORMATION

Funding Agency: _____
Insurance: _____
ID #: _____
Contact Person: _____
Contact Person Phone: _____

REASONS FOR PLACEMENT

Describe the specific incident or behavior that recently occurred to precipitate the need for this referral:

Describe the behavior(s) that the youth has engaged in historically that supports his need for residential treatment:

Describe what specific sexually harmful behavior the youth has engaged in that requires the need for sex specific treatment:

Previous placement history: _____

Youth's current attitude toward treatment: _____

Date of last completed diagnostic assessment: _____
(Please provide us a copy of the completed assessment)

What "Level of Care" Assessment has been completed (Example: CASII): _____
Date of Completion: _____ Completed By: _____
(Please provide us a copy of the completed assessment)

Has the Strengths and Difficulties Questionnaire (SDQ) been completed? _____

Date of Completion: _____ Completed By: _____
(Please provide us a copy of the completed assessment)

FAMILY INFORMATION

Who is comprised of this youth's "family"? (biological family, foster care family, adoptive family, extended family connections?): _____

Has this youth been adopted? (Highlight One) Yes No If yes, at what age? _____

Names of Parent(s)/Guardian(s) and Family Members:

Relationship to Youth:

Primary Family Legal Address: _____

Phone: _____ Fax: _____ Email: _____

Will the family be a resource and involved in treatment?: _____

When was the last time that the youth lived with his family?: _____

Has the youth experienced a lot of family disruptions?: _____
Is yes, please explain disruptions (multiple foster care placement, multiple moves, family rights terminated, etc.): _____

What is the projected discharge option?: _____

EDUCATIONAL HISTORY:

Current Grade: _____ (Circle One if Applicable) Diploma Obtained GED Obtained
Last Known IQ: _____

Special Education Classification:
_____ Learning Disability
_____ Emotional/Behavioral Disability
_____ Other

Does the youth have a Current IEP? _____

Are there any identified special considerations to assist with education or learning style (Ex. Auditory learning, special test taking requirements): _____

School District of Legal Residence: _____
Legal School District Contact Person/Title: _____
Address: _____
Phone: _____ Fax: _____ Email: _____
Last School the Youth Attended: _____
Contact Person Name: _____
Contact Person Phone Number: _____
School Address: _____

Overview of Youth's Behavior at School: _____

MEDICAL HISTORY:

Current Medical Issues: _____

Any Allergies? If yes, please explain: _____

Any Physical Disabilities? If yes, please explain: _____

Are there any medical or physical restrictions? Please explain: _____

Please list medications that the youth is taking to address any medical concerns (Ex. Inhaler, epi-pen): _____

Is there any medical or physical reason that this youth should not be restrained or held in case of emergency? _____
If yes, please explain: _____

PSYCHIATRIC/BEHAVIORAL HISTORY:

Psychiatric Hospitalization History (please include hospital & dates of hospitalization): _____

Current Psychiatric Diagnosis (DSM Diagnosis): _____

Current Medications: _____

History of Medications: _____

Is there anything we should know about medications that have that have been attempted, tried, recommended? _____

Is there any psychological reason that this youth should not be restrained or held in case of emergency? _____
If yes, please explain: _____

Psychiatric/Behavioral Concerns

	<u>PAST</u>	<u>CURRENT</u>	<u>EXPLAIN FREQUENCY & SEVERITY</u>
Sexual Abuse (Circle one or both) Victim/Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional Abuse (Circle one or both) Victim/Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Abuse (Circle one or both) Victim/Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Assaultive/Aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cruelty to Animals	<input type="checkbox"/>	<input type="checkbox"/>	_____

Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stealing/Shoplifting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Running Away	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gang Activity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ongoing Disruptive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oppositional/Argumentative	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emerging Personality Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor Impulse Control	<input type="checkbox"/>	<input type="checkbox"/>	_____
Short Attention Span	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lacks Emotion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appears Anxious	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rapid Mood Changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicidal Ideation/Threats	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self-Injurious Behavior (List methods)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pervasive Developmental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autism/Aspergers Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual Preoccupation/Fetishism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gender Identity Issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor Hygiene/Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating Disorder (binge, purge, starve, hoards food, excessive exercising, obsessions with weight, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Encopresis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please list):	<input type="checkbox"/>	<input type="checkbox"/>	_____

Is there a known history of psychiatric disorders within the family? _____
 If yes, please list which ones and whom: _____

Is there a known history of drug or alcohol abuse within the family? _____
 If yes, please list what and whom: _____

Does the youth have a chemical dependency issue that requires a screen/Detox or special needs associated with chemical health? _____

Can the youth complete all his ADL's ("Activities of Daily Living," i.e. use the toilet, bath self, cloth self, feed self, etc.)
 Yes or No
 If no, please explain: _____

How many restraints has the youth required in the past? _____
 What is youth's most recent restraint activity? _____
 What cultural issues do staff need to be sensitive to and integrate into treatment? _____

Is the youth vulnerable to be picked on or victimized by other peers? (Please explain) _____

Please list sexual offense charges, if any: _____

Please list nonsexual criminal charges, if any: _____

Youth's Strengths: _____

Please explain overall concerns: _____

Form Completed By: _____

Signature

Date Completed

This Section for Office Use Only

Documents Reviewed: _____

Is the program able to meet the youth's needs?

Cultural	Y	N
Emotional	Y	N
Education	Y	N
Mental Health	Y	N
Physical	Y	N
Safety	Y	N

Approved for Placement	Y	N
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If no, please explain and document recommendation: _____

If yes, Comments/Other Considerations/Recommendations/Instructions: _____

Approved By: _____

Signature

Name & Title

Date

Thank you for completing this admissions form. An admissions coordinator will contact you shortly. In the meantime, please compile the following documentation:

Consents & Previous Records:

- Consent for release of information to Mille Lacs Academy
- Copy of any completed Diagnostic Reports
- Copy of Strengths and Difficulties Questionnaire (SDQ)
- Copy of Level of Care Assessment (Example: CASII)
- Social history/Placement history
- Psychological Evaluation (recent)
- Psychiatric Evaluation (recent)
- Sexuality Assessment
- Current Safety Plan

Legal Documents:

- JSO Registration Form
- Interstate Compact Agreement
- Birth Certificate (copy/original)
- Social Security Card/#:
- Court Order (authorizing residential tx.)
- Probation Order
- Probation Social Investigation
- Parole Order
- Medical Card/Insurance Card

Medical Records:

- Immunization Record
- Physical Exam (within past year)
- Dental Exam (within past year)
- Vision Exam/Screening (within past year)
- Hearing Exam/Screening (within past year)
- Psychiatric Hospitalization Records (specify):
- Other Medical Records (specify):

Educational Records:

- Current Individualized Education Plan (IEP)
- Current IEP Triennial Evaluation Reports (ex. school social history; school psychological report)
- High School Diploma
- GED