

INTENSIVE DAY TREATMENT REFERRAL FORM



Please complete this form to the best of your knowledge, print, and fax to the attention of Glenn Dallmann – Fax: 218-728-7501 – E-mail: gdallmann@woodlandhills.org – Phone: 218-728-7500 ext. 143. You will be contacted within one business day to verify receipt of your referral. Thank you for choosing Woodland Hills!

Client Information				
Client's Full Name	Nickname	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Birth	Place of Birth	Social Security No.		
Last Known or Permanent Address	City	State	Zip	
Home Phone	Current Placement or location	Height	Weight	
Race/Ethnicity	Primary Language	Spiritual or religious affiliation		
Tribal Affiliation, if any	Is client adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age at first adoption?	# finalized adoptions?	Is client a State Ward? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Insurance Provider and Policy No.				
Primary:		Secondary:		
Legal Status of Placement <input type="checkbox"/> Delinquency <input type="checkbox"/> EJJ <input type="checkbox"/> CHIPS <input type="checkbox"/> Voluntary		Judge's Name		
Date and Time of Court Hearing	Court File No.			

Contact Information			
Parent/guardian			
(1) Parent/Guardian name	Parent's Date of Birth	Client lives with this parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
(2) Parent/Guardian name	Parent's Date of Birth	Client lives with this parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Who has custody of the client?			
Any restrictions on either parent's involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what?			
Will the parent(s)/guardian(s) be supportive of and/or involved with this placement? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why?			
Lead Worker			
Referring agency	Worker's name	Phone	
Street address	City	State	Zip
E-mail	Cell	Fax	

Other Professionals Currently Working with this Client		
Agency	Worker's Name	Phone
Agency	Worker's Name	Phone
Agency	Worker's Name	Phone
Agency	Worker's Name	Phone
Current School		
School and/or District #	School Contact for this Client:	Phone
Client's current grade level?	Does the client have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	IEP for what disability?

Client Profile

What are the presenting problems that lead to this referral?	
What is the history of or contributing factors to the client's problems?	
What are some of the client's assets, strengths, interests or abilities?	
Current/Most Recent Diagnosis	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	Date of Assessment?
List client's current medications.	
Any health concerns or physical limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Any cognitive, developmental, or IQ concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Any school related problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Currently suicidal? Any history of suicide or self-harm? Any hospitalizations for mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Any chemical abuse? Any Treatment History? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Any history of abuse, neglect, or trauma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Any safety concerns of client being vulnerable with his/her peers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	
Any history of this client victimizing or hurting others? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:	

Delinquency History (or attach an offense history report)			
Current to Prior Offenses	Class/Degree	Offense Date	Disposition

History of Services Delivered

Outpatient Services		
Name of Agency	Dates of Service	Result

Residential Services		
Name of Agency	Dates of Service	Result

Services You Are Requesting

What treatment goals do you have for your client?

What additional services does your client need?

What is the post-placement plan for your client?

Supporting Documentation to be Provided When Applicable

- | | |
|--|--|
| <input type="checkbox"/> Psychological or Diagnostic Assessments | <input type="checkbox"/> Individual Education Plan (IEP) |
| <input type="checkbox"/> Psychiatric Reports | <input type="checkbox"/> Program Discharge Reports |
| <input type="checkbox"/> Social/Family Assessments | <input type="checkbox"/> Substance Abuse Assessments (Rule 25) |
| <input type="checkbox"/> Court Reports | <input type="checkbox"/> CASSI or YLSI assessment |
| <input type="checkbox"/> Copy of Court Orders | <input type="checkbox"/> Other: |

Use this space for any additional information you wish to share.

Thank you