

REFERRAL FORM

Chisholm House, Residential Treatment Services for Corrections, Semi-Independent Living, or Residential Treatment Services for Mental Health



Please complete this form to the best of your knowledge, and then send to the attention of Glenn Dallmann, Admissions Coordinator – 4321 Allendale Ave. Duluth, MN 55803 – 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!

Referral to which program?

<input type="checkbox"/> Chisholm House – Length of stay? _____ days	<input type="checkbox"/> Residential Treatment Services for Mental Health
<input type="checkbox"/> Residential Treatment Services for Corrections	
<input type="checkbox"/> Semi-Independent Living Program	

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? <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			
Date and Time of Court Hearing	Judge's Name	Court File No.	

Contact Information

Parent/guardian			
(1) Parent(s)/Guardian(s) 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(s)/Guardian(s) 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	State	City	Zip
E-mail	Cell	Fax	
Other Professionals 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	
Street Address	City	State	Zip
Client's current grade level?	Does the client have an IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Client Profile

What are the presenting problems that lead to requiring an out-of-home placement?

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?

Designated SED? Yes No

List client's current medications.

Any cognitive, developmental, or IQ concerns?

Yes No If yes, explain:

Currently suicidal? Any history of suicide or self-harm? Any hospitalizations for mental health?

Yes No If yes, explain:

Any chemical abuse?

Yes No If yes, explain:

Any history of abuse, neglect, or trauma?

Yes No If yes, explain:

Any health concerns or physical limitations?

Yes No If yes, explain:

Any safety concerns of client being vulnerable with his/her peers while in a placement?

Yes No If yes, explain:

Any history of this client victimizing others? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
Any history of absconding? <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	Successful Completion?
Residential Services		
Name of Agency	Dates of Service	Successful Completion?

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"/> Copy of Out-of-Home Placement Plan
<input type="checkbox"/> Copy of Court Orders	<input type="checkbox"/> Voluntary Placement Agreement
<input type="checkbox"/> CASSI or YLSI assessment	<input type="checkbox"/> Other:
Use this space for any additional information you wish to share. 	

Thank you