



Referral Information Checklist

Please include the following information when making a referral to Avanti Center for Girls:

- Completed referral information form
- Relevant legal documentation (custody papers, court orders)
- Copies of insurance cards
- Clinical information including:
 - Most recent Psychological/Psychiatric Assessment/Diagnostic Assessment.
 - Treatment summaries and recommendations (hospital, day treatment, outpatient).
 - All Psychological/Neuropsychological testing reports
- Most recent Individualized Education Program (IEP) including any testing/assessment done by the school district.
- All medical health records including past and current medications and supplements.

Please send completed referral form and documentation to:

Avanti Center for Girls, ATTN: Melody Rossiter

Telephone: 763.252.4526

Fax: 888.972.8981

Email: melody.rossiter@voamn.org

Mail: 10300 Flanders St NE

Blaine MN 55449

Please note the following:

Incomplete applications will not be considered for placement.

All areas on the referral form must be complete and all relevant clinical documentation submitted.

Referrals must include formal documentation of the client's status/situation **within the three months prior to referral.**



Dear Parent/Guardian,

Thank you for your interest in Avanti's residential treatment program. Our 5 ½ - 8 ½ month long program works with adolescent girls experiencing mental health crisis.

Families seeking our services are frequently unsure about where to turn for help and often see residential treatment as a last resort for their daughter. We assure you that we understand how difficult this decision is and are here to help you each step of the way. Our program, based on Dialectical Behavioral Therapy (DBT), has a successful track record and we are confident we will be able to make lasting change in your daughter's life.

Once your daughter has been accepted to our program you will be contacted by the Intake Coordinator at Avanti to set-up an intake meeting. Parents /guardians need to accompany the child to the intake meeting, social workers and other treatment team members are also encouraged to attend. Your support during this often anxious time for your daughter is very important.

It can be difficult convincing children that residential treatment is necessary and beneficial for them, we have found that bringing girls without their knowledge can be a traumatic experience and leads to resentful feelings towards parents and Avanti treatment staff.

Parental involvement is crucial for your daughter's success in treatment. In addition to phone and in-person visits, parents participate in developing treatment plans and support team meetings. Parents are also expected and encouraged to participate in our parent orientation group, DBT family skills group and family therapy. Family therapy will begin within two weeks after intake. Visits are limited to on grounds for the first month of treatment and gradually increased to off-grounds and home visits when behaviors are stabilized. As your daughter progresses in treatment, home visits increase to provide the most opportunity for successful reintegration home.

Residents participating in our evaluation or shelter programs have different visit guidelines; staff will provide details at intake.

Allison Cross, MA LMFT
Program Director-Avanti



Please only check the program that is being referred to:

- I understand that the Avanti Treatment Program is a 5 1/2-8 1/2 month long program. ____ (initials)
 I understand that the Avanti Evaluation Program is a 42 day long program. ____ (initials)
 I understand that the Avanti Shelter Program is up to 90 days long program. ____ (initials)

Referral Information Form

Client Information			
First Name:	Middle Name:	Last Name:	
Date of Birth:	Age:	Sex:	SSN:
Address:		Phone:	
Ethnicity:	Religion:	Language(s) Spoken:	
Where is person being referred currently residing?			
Parent/Guardian Information			
Mother Name:		DOB:	SSN:
Address:		Phone:	
		Email:	
Father Name:		DOB:	SSN:
Address:		Phone:	
		Email:	
Guardian Name(s):		DOB:	SSN:
Address:		Phone:	
Custody (Complete if parents do not reside together)			
Legal Custody: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Joint <input type="checkbox"/> Other (specify):			
Physical Custody: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Joint <input type="checkbox"/> Other (specify):			
<input type="checkbox"/> I have provided a copy of custody paperwork (if applicable). ____ (initials)			
County Information			
Social Worker Name:		County:	
Address:		Phone:	
Email:		Fax:	
Probation Officer:		County:	
Address:		Phone:	
Email:		Fax:	
Guardian ad Litem Name:		County:	
Address:		Phone:	
Email:		Fax:	
Insurance Information			
Primary Health Insurance Company:		Subscriber name and DOB:	
Policy or ID #	Group #	Phone:	
Secondary Health Insurance:		Subscriber name and DOB:	
Policy or ID #	Group #	Phone:	
Dental Insurance:		Subscriber name and DOB:	
Policy or ID #	Group #	Phone:	



Pharmaceutical Provider:	Phone:
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Clinical Information

Current DSM 5 Diagnosis

Is this client a danger to self?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this client a danger to others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this client at risk of running away from treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the client have a history of physically assaulting anyone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the client have a history of perpetrating sexual abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this client have a history of substance use/abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this client have a history of eating disorder behaviors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Restricting <input type="checkbox"/> Purging <input type="checkbox"/> Other (specify):		

What is current BMI?

If you answered "yes" to any of the above questions, please provide details:

Current Treating Mental Health Professional:	Credentials:	Phone:
Address:	Fax:	

Treatment History (Please fill out completely)

Has this client had previous trauma therapy? Yes No **Completed?** Yes No

Type of setting:	Provider Name:	Dates of Service:
<input type="checkbox"/> Outpatient Services <input type="checkbox"/> Day Treatment <input type="checkbox"/> Hospital <input type="checkbox"/> Residential		
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Current Medications

Name	Dosage
Name	Dosage
Name	Dosage
Name	Dosage
Name	Dosage
Current Medication Prescriber:	Phone:
Address:	Fax:



Are any of the above medications given by injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client broken a bone in the last month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client in the process of any dental work beyond normal fillings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does this client currently have braces?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the client ever had a positive Mantoux test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client pregnant or postpartum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	
Does the client have any food or drug allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	
Is the client free of communicable diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client taking any medications to manage seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have mobility issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:	
If you answered yes to any of the above medical questions, you will be contacted by our nurse prior to acceptance.	
Please list all current and previous medical diagnosis:	
Please give a brief description of presenting symptoms:	
Educational Information	
Last School Attended:	
School District:	
Address:	
Phone:	
Grade:	School Contact Person:
Fax:	
Individualized Education Plan (IEP) – If yes, please attach a copy for our records:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Diagnosis:	Secondary Diagnosis:
<input type="checkbox"/> I have provided a copy of the Individualized Educational Plan (if applicable). ____ (initials)	