Volunteers of America
Minnesota

Avanti
10300 Flanders St NE Blaine, MN 55449
Phone 763.230.7470 Fax 888.972.8981
www.voamn.org

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: Jill Badowich
Telephone: 763.252.4526
Fax: 888.972.8981
Email: jill.badowich@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.**

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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

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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: ☐Mother ☐Father ☐ Joint ☐ Other (specify):
Physical Custody: ☐Mother ☐Father ☐ Joint ☐ Other (specify):
☐ **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:	
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:

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Pharmaceutical Provider:	Phone:

Clinical Information		
Current DSM 5 Diagnosis		
Is this client a danger to self?	☐ **Yes**	☐ **No**
Is this client a danger to others?	☐ **Yes**	☐ **No**
Is this client at risking of running away from treatment?	☐ **Yes**	☐ **No**
Does the client have a history of physically assaulting anyone?	☐ **Yes**	☐ **No**
Does the client have a history of perpetrating sexual abuse?	☐ **Yes**	☐ **No**
Does this client have a history of substance use/abuse?	☐ **Yes**	☐ **No**
Does this client have a history of eating disorder behaviors? ☐Restricting ☐Purging ☐ Other (specify):	☐ **Yes**	☐ **No**
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:
☐ Outpatient Services ☐ Day Treatment ☐ Hospital ☐ Residential		
☐ Outpatient Services ☐ Day Treatment ☐ Hospital ☐ Residential		
☐ Outpatient Services ☐ Day Treatment ☐ Hospital ☐ Residential		
☐ Outpatient Services ☐ Day Treatment ☐ Hospital ☐ Residential		
☐ Outpatient Services ☐ Day Treatment ☐ Hospital ☐ Residential		

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

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Are any of the above medications given by injection?	☐ Yes ☐ No
Has the client broken a bone in the last month?	☐ Yes ☐ No
Is the client in the process of any dental work beyond normal fillings?	☐ Yes ☐ No
Does this client currently have braces?	☐ Yes ☐ No
Has the client ever had a positive Mantoux test?	☐ Yes ☐ No
Is the client pregnant or postpartum?	☐ Yes ☐ No
If yes, please explain:	
Does the client have any food or drug allergies?	☐ Yes ☐ No
If yes, please explain:	
Is the client free of communicable diseases?	☐ Yes ☐ No
Is the client taking any medications to manage seizures?	☐ Yes ☐ No
Does the client have mobility issues?	☐ Yes ☐ 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:**		☐ Yes ☐ No
Primary Diagnosis:	Secondary Diagnosis:	
☐ **I have provided a copy of the Individualized Educational Plan (if applicable). ____ (initials)**		