Volunteers of America
MINNESOTA AND WISCONSIN

Resident Facesheet and Pre-Admission Assessment

Avanti ◆ Bar-None Residential Treatment Services ◆ Children's Residential Treatment Center ◆ Omegon

Date:

Client Information				
First Name:	**Middle:**		**Last Name:**	
Date of Birth:	**Age:**	**Sex:**	**Nickname:**	
Address:			**SSN:**	
City:		**State:**	**Zip Code:**	
Referral source:			**Place of birth:**	
Child's current location (home, hospital, shelter etc.):			**Languages spoken/written:**	
Identifying characteristics (hair/eye color/tattoos etc.):				
Race/Cultural Heritage/Native American Tribal Affiliation:				
Mother's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Father's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Other/Guardian's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Is the child adopted? ☐ **Yes** ☐ **No**		**At what age?**		
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)**			**Is this a court ordered placement?** ☐ **Yes** ☐ **No**	
Is anyone restricted from contact with the child? ☐ **Yes** ☐ **No**		**Name:**		**Relation:**
Last school attended:			**Contact name/phone:**	**Grade:**
Social Worker Name:			**County:**	**Contact in an emergency?**
Address:			**Phone:**	☐ Yes ☐ No
Email:			**Fax:**	
Probation Officer Name:			**County:**	**Contact in an emergency?**
Address:			**Phone:**	☐ Yes ☐ No
Email:			**Fax:**	
Children's Mental Health Case Manager:			**County:**	**Contact in an emergency?**
Address:			**Phone:**	☐ Yes ☐ No
Email:			**Fax:**	
Rule 25 Funding Authorizer (if applicable):			**County:**	
Address:			**Phone:**	
Email:			**Fax:**	
Insurance Information				
Primary Health Insurance:			**Subscriber name:**	
Policy or ID#	**Group:**		**Phone:**	
Secondary Health Insurance:			**Subscriber name:**	
Policy or ID#	**Group:**		**Phone:**	
Financially Responsible Party (parent/guardian/county etc.):			**MA#:**	

Office Use Only Below

Client Number/Unit:

Admission Date/Time:

Clinical Coordinator:

Discharge Date:

Diagnosis at Intake:

Clinical Information			
Presenting Problems (what has happened to prompt the search for treatment right now):			
Is this client currently experiencing hallucinations/delusions?		☐ Yes ☐ No	
Is this client a danger to self?		☐ Yes ☐ No	
Is this client a danger to others?		☐ Yes ☐ No	
Is this client at risk of running away from treatment?		☐ Yes ☐ No	
Does this client have a history of physically assaulting anyone?		☐ Yes ☐ No	
Does this client have a history of property destruction		☐ Yes ☐ No	
Does this client have a history of perpetrating sexual abuse?		☐ Yes ☐ No	
Does this client have a history of eating disorder behaviors?		☐ Yes ☐ No	
☐ Restricting ☐ Purging ☐ Other (please specify):			
If you answered "yes" to any of the above questions, please provide details in the appropriate boxes.			
Client's strengths:			
Current MH Professional/Therapist:		**Phone:**	
Address:		**Fax:**	
Current Psychiatrist:		**Phone:**	
Address:		**Fax:**	
Date and location of most recent psychological/neurological testing:			

Treatment History		
Type of Setting: ☐ **outpatient** ☐ **inpatient** ☐ **hospital** ☐ **day treatment**	**Provider Name:**	**Estimated dates of service:**
Type of Setting: ☐ **outpatient** ☐ **inpatient** ☐ **hospital** ☐ **day treatment**	**Provider Name:**	**Estimated dates of service:**
Type of Setting: ☐ **outpatient** ☐ **inpatient** ☐ **hospital** ☐ **day treatment**	**Provider Name:**	**Estimated dates of service:**
Type of Setting: ☐ **outpatient** ☐ **inpatient** ☐ **hospital** ☐ **day treatment**	**Provider Name:**	**Estimated dates of service:**
Type of Setting: ☐ **outpatient** ☐ **inpatient** ☐ **hospital** ☐ **day treatment**	**Provider Name:**	**Estimated dates of service:**
Type of Setting: ☐ **outpatient** ☐ **inpatient** ☐ **hospital** ☐ **day treatment**	**Provider Name:**	**Estimated dates of service:**

Medications/Medical					
Please list client's current medications: **Dr. prescribing these meds:**			**Are any given by injection?** ☐ Yes ☐ No **Phone:**		
Address:			**Fax:**		
Has the client had a concussion or TBI?	☐ Yes ☐ No	Date:			
Has the client ever had a seizure?	☐ Yes ☐ No	**On seizure meds?**	☐ Yes ☐ No	**Date of last EEG:**	
Does the client have Diabetes? ☐ Yes ☐ No ☐ Type 1 ☐ Type 2		**On diabetes meds?**	☐ Yes ☒ No	**Medication name:**	
Has the client broken a bone in the last month?	☐ Yes ☐ No				
Does the client currently have braces on teeth?	☐ Yes ☐ No				

Has the client ever had a positive Mantoux (Tuberculosis) test?	☐ Yes* ☐ No ***If yes, a chest x-ray is required before admission***
Does the client have any food, animal or drug allergies?	☐ Yes ☐ No **Do they have an epi pen?** ☐ Yes ☐ No
***List allergies/reactions:**	
Any special dietary requirements?	☐ Yes* ☐ No ***If yes, please explain:**
Has the client ever had asthma?	☐ Yes ☐ No **Last time they needed an inhaler:**
Any serious, chronic or communicable diseases?	☐ Yes* ☐ No ***If yes, please explain:**
Any cardiac issues? ☐ Yes* ☐ No	***If yes, please explain:** **Date of last EKG:**
Does the client have mobility issues? ☐ Yes ☐ No	
If yes, please explain:	

Primary Care Physician/Clinic:	**Phone:**
Address:	**Fax:**
Dentist/Dental Clinic:	**Phone:**
Address:	**Fax:**
Are there any pending or ongoing medical appointments? ☐ Yes ☐ No **Please explain:**	

Educational Information	
Last school attended:	**Current Grade:**
Address:	**School contact person:**
Home School District:	**IQ:**
Individualized Education Plan (IEP)? ☐ Yes* ☐ No	***If yes, please attach a copy and IEP evaluation for our records**

Legal Information	
Is the client court ordered to attend treatment?	☐ Yes ☐ No ***If yes, please attach a copy of court order.**
Is the client an adjucated deliquent?	☐ Yes ☐ No
Does the client have assault charges?	☐ Yes ☐ No
Please briefly describe all legal charges or pending charges:	

Motivation		
Does the client believe they have a problem with drugs and/or alcohol?	☒ Yes ☐ No ☐ NA	
Have they had a Rule 25 (Chemical Dependency) evaluation?	☐ Yes ☐ No ☐ NA	
Does the client want help getting sober?	☐ Yes ☐ No ☐ NA	
Does the client know someone is looking into long term treatment for them?	☐ Yes ☐ No ☐ NA	
Does the client know the program's length of stay is at least 3 months?	☐ Yes ☐ No ☐ NA	
Is the family/guardian willing to participate in 4 hours of family therapy a month?	☐ Yes ☐ No ☐ NA	
Does the family/guardian know that Omegon, Avanti and Bar-None are not locked facilities?	☐ Yes ☐ No ☐ NA	
Anything else we should know?		

Name of person filling out application:	**Signature:** **Date:**

FOR OFFICE USE ONLY BELOW:	
Current CD Dx:	
History Trauma:	

Initial Concerns/Comments:			
Final Review Date:		**Reviewer:**	
Interventions:			
Strengths:			
Is program appropriate/needed:	☐ Yes ☐ No		
Is program able to meet client's cultural, emotional, educational, mental health, chemical and physical needs:			☐ Yes ☐ No
Primary MH or CD?	☐ MH ☐ CD (Omegon only)		
Reviewer signature:		**Date:**	