



Bar-None Residential Treatment Services

22426 St. Francis Blvd.

Anoka, MN 55303

www.voamn.org

Phone 763-753-2500 Fax 888-965-5125

Referral Information Checklist

Please include the following information when making a referral to Bar-None.

- 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 (within the last 6 months)
 - ✚ Treatment summaries (hospital, day treatment, outpatient)
 - ✚ Psychological/Neuropsychological testing reports
- Most recent Individualized Education Program (IEP) and IEP Evaluation
- Immunization records

Send to:

Bar-None Residential Services

ATTN: Sara Ballstadt

Fax: 888-965-5125

Email: sara.ballstadt@voamn.org

Mail: 22426 St. Francis Blvd.

Anoka, MN 55303

Bar-None Referral Information Form

Date: _____

CLIENT INFO					
Name <i>(last, first, middle)</i> :				Admission Unit:	
Nickname:		DOB:		Admit Date/Time:	
Age:	Sex:	Place of Birth:		IQ:	SSN:
Court ordered:	Custody:	Adjudicated:		Religious activities: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race:	Language:	Tribal affiliation:		Spiritual affiliation:	
Primary Medical Doctor/Clinic: <small>(address & phone)</small>			Last school attended: <small>(address, phone & contact)</small>		
SDRS: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			District #:		Grade:
REFERRING AGENT					
Name:		County:		Phone:	Fax:
REASON FOR REFERRAL					
Previous or current charges?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
Is the youth a danger to him/herself?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
If yes, have there been any recent or significant suicide attempts?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
Is the youth a danger to others?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
Chemical abuser and/or chemically dependent?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
Have there been any inappropriate sexual behaviors?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
If yes, is youth a sex offender?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
Is youth currently hallucinating or having delusions or any concerns of this within the last three months?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:	
Previous DA?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	
Where is youth currently? (name & address) <small>(Admissions from Rice Institute, Willmar Mon-Thurs due to 1 day of medication given upon discharge.)</small>					
Reason for referral/presenting problems:					
If evaluation, what specifically are you looking for?					
Youth strengths?					
Is the youth an insulin-dependent Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No				Explain:	
Has the youth ever been diagnosed with a concussion or TBI? <input type="checkbox"/> Yes <input type="checkbox"/> No				Explain:	
Are they taking meds to manage seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No				Explain:	
Does the youth have any food/drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No				Explain:	
Does the youth need an Epi-Pen for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No				Explain:	
Hx of major illnesses, surgeries, broken bones? <input type="checkbox"/> Yes <input type="checkbox"/> No				Explain:	
Has the youth ever had a positive Mantoux? <input type="checkbox"/> Yes <input type="checkbox"/> No				Explain:	
Any pending medical/dental appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No				Explain:	
Current medications, including injectable meds, and prescribing physician:					
If you answered YES to any of the above medical questions, you will be contacted by our nurse prior to acceptance.					

COUNTY INFO	
Social Worker: Address: Phone: Fax: Email:	Probation Officer: Address: Phone: Fax: Email:
PARENT INFO	
Mother: Address: Phone: Email: DOB:	Father: Address: Phone: Email: DOB:
BILLING INFO	
Current MA #	MA Verified <input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Info	Policy Holder's Name
ID/Policy #	Policy Holder's DOB
Group #	Relationship to Youth
Per Diem Billing (county or insurance)	Medical Billing (insurance or MA)
BAR-NONE MENTAL HEALTH SCREENING ASSESSMENT	
Person screening	
Diagnosis at Intake DSM V (ICD-10)	
How is the program able to meet the youth's needs? (Cultural, emotional, educational, mental health, physical, etc.):	
Do further assessments need to be completed such as the POSIT and/or Rule 25? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<input checked="" type="checkbox"/> Complete all intake assessments	
<input type="checkbox"/> Other assessments, explain:	
Accepted for Program <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, explain:	
Program recommended:	
COLLATERAL DOCUMENTATION	