Volunteers of America MINNESOTA

CRTC Referral Admission Assessment

Client Name:	**Date:** Click here to enter a date.
Male ☐ **Female** ☐ **Other:**	**Referral Source:**
Age: **DOB**: Click here to enter a date.	**Phone:**
Home Address:	**Fax:**
	Email:
Race:	**County:**
Parent/Guardian(s) Name/Contact Info:	**Parent/Guardian(s) Name/Contact Info:**
Current Custody Arrangement:	**Mom** ☐ **Dad** ☐ **Other:**
Other parties involved:	**Contact Information:**
Court Ordered ☐ **Voluntary Placement** ☐	**Currently at:**

Items needed for screening for appropriateness of placement: Insurance/funding information (copy of insurance card, SSN, background info from previous placements, psychological/diagnostic assessment, psychological testing, chemical assessments, current IEP, IQ, case plan goals (if county referral), client placement authorization (CPA)(if county referral), court order, current physical exam records, immunizations records, ample supply of meds, county case management plan, out of home placement plan.

IQ:	**Psych testing w/in past 6/12 months:** Yes ☐ No ☐	**Where?**

Current IEP: Yes ☐ No ☐	**Current school**:	**Grade:**
IEP requested: Yes ☐ No ☐	**Prior schools:**	

Presenting problems:
Previous mental health symptoms or dx:
Current meds (need 1 weeks' supply at intake):
Current physical exam: Yes ☐ No ☐ **Details:**
Current immunizations: Yes ☐ No ☐ **Details:**
Chronic health/medical issues/allergies: Yes ☐ No ☐ **Details:**
Previous mental health/CD treatment facilities and hospitalizations (include psychiatry and most recent therapist):

Is the youth a danger to self? Yes ☐ No ☐	**Is the youth a danger to others?** Yes ☐ No ☐
Physically assaultive? Yes ☐ No ☐	**Likely to engage in sexual abusive bx?** Yes ☐ No ☐
Chemically dependent? Yes ☐ No ☐ **If yes, Rule 25 completed?** Yes ☐ No ☐	**Family will participate in program (we require 4 hours family therapy per month)?** Yes ☐ No ☐

Run risk? Yes ☐ No ☐		**Informed length of stay (6-12 mos.)** Yes ☐ No ☐
If yes, please explain:		
Collateral info requests:		
Psychological report? Yes ☐ No ☐		**Psychiatric reports?** Yes ☐ No ☐
Tx summaries from previous placements? Yes ☐ No ☐		
Funding:		
County:	**MA:**	**PMAP:**
Private insurance:		**Policy holder name:**
ID #:		**Policy holder DOB:**
Group #:		**Relationship to youth:**
Authorization obtained? Yes ☐ No ☐		**Authorization #:**
CRTC Review of Referral (internal use only):		
Date of review:		**Reviewer:** Elizabeth Williams, M.A., LMFT Program Director
Other parties involved:		**Contact Information:** 612-278-4230
Recommendations/Concerns:		
CRTC treatment appropriate/needed: Yes ☐ No ☐		
Program able to meeting client's cultural, emotional, educational, mental health, and physical needs: Yes ☐ No ☐		
If yes, admitting DSM V diagnosis:		