

## CRTC Referral Admission Assessment

<b>Client Name:</b>		<b>Date:</b> <a href="#">Click here to enter a date.</a>	
<b>Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/> <b>Other:</b>		<b>Referral Source:</b>	
<b>Age:</b> <b>DOB:</b> <a href="#">Click here to enter a date.</a>		<b>Phone:</b>	
<b>Home Address:</b>		<b>Fax:</b>	
		<b>Email:</b>	
<b>Race:</b>		<b>County:</b>	
<b>Parent/Guardian(s) Name/Contact Info:</b>		<b>Parent/Guardian(s) Name/Contact Info:</b>	
<b>Current Custody Arrangement:</b>		<b>Mom</b> <input type="checkbox"/> <b>Dad</b> <input type="checkbox"/> <b>Other:</b>	
<b>Other parties involved:</b>		<b>Contact Information:</b>	
<b>Court Ordered</b> <input type="checkbox"/> <b>Voluntary Placement</b> <input type="checkbox"/>		<b>Currently at:</b>	
<i>Items needed for screening for appropriateness of placement:</i> 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.			
<b>IQ:</b>	<b>Psych testing w/in past 6/12 months:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Where?</b>	
<input type="checkbox"/>	<input type="checkbox"/>		
<b>Current IEP:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Current school:</b>	<b>Grade:</b>	
<b>IEP requested:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Prior schools:</b>		
<input type="checkbox"/>			
<b>Presenting problems:</b>			
<b>Previous mental health symptoms or dx:</b>			
<b>Current meds (need 1 weeks' supply at intake):</b>			
<b>Current physical exam:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Details:</b>			
<b>Current immunizations:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Details:</b>			
<b>Chronic health/medical issues/allergies:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Details:</b>			
<b>Previous mental health/CD treatment facilities and hospitalizations (include psychiatry and most recent therapist):</b>			
<b>Is the youth a danger to self?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Is the youth a danger to others?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Physically assaultive?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Likely to engage in sexual abusive bx?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Chemically dependent?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Family will participate in program (we require 4 hours family therapy per month)?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>If yes, Rule 25 completed?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			

Run risk? Yes <input type="checkbox"/> No <input type="checkbox"/>		Informed length of stay (6-12 mos.) Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, please explain:			
<i>Collateral info requests:</i>			
Psychological report? Yes <input type="checkbox"/> No <input type="checkbox"/>		Psychiatric reports? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Tx summaries from previous placements? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Funding:</b>			
County:		MA:	PMAP:
Private insurance:		Policy holder name:	
ID #:		Policy holder DOB:	
Group #:		Relationship to youth:	
Authorization obtained? Yes <input type="checkbox"/> No <input type="checkbox"/>		Authorization #:	
<b>CRTC Review of Referral (internal use only):</b>			
Date of review:		Reviewer: Kelly Wesner, MSW, LICSW Interim Program Director	
Other parties involved:		Contact Information: kwesner@voamn.org	
Recommendations/Concerns:			
CRTC treatment appropriate/needed: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Program able to meeting client's cultural, emotional, educational, mental health, and physical needs: Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, admitting DSM V diagnosis:			