Volunteers of America®
Minnesota

Children's Residential Treatment Center
143 East 19th Street · Minneapolis, MN 55403
Phone 612.870.4300 · Fax 888.965.5129

Referral Information

Referral Information Checklist

Please include the following when making a referral to CRTC:

- ☐ Referral Information Form (attached)
- ☐ Relevant legal documentation (e.g. Custody Papers, Court Orders)
- ☐ Insurance Cards
- ☐ Clinical Information including:
  - Most recent Psychological/Psychiatric/Diagnostic Evaluations
  - Treatment summaries (e.g. hospitalizations, day treatment, outpatient, other residential programs).
  - Psychological / Neuropsychological testing (e.g. MMPI, MACI, WISC, Projectives, FSIQ)
- ☐ Most recent Individualized Education Program (IEP)
- ☐ **Anything else that would be helpful in order for CRTC to better understand the needs of your child/client**

Referral Information should be sent to:

Children's Residential Treatment Center
Attn: Emily Stolarski, Intake Coordinator

Phone:	612.278.4221
Email (preferred):	estolarski@voamn.org
Fax:	888.965.5129
Mail:	Emily Stolarski, Intake Coordinator 143 East 19th Street Minneapolis, MN 55403

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Referral Information

Client Information

Name	First	Nickname	Middle	Last
Date of Birth	Age	Sex	SSN	
Address		City, State, Zip	Phone	
Ethnicity	Religion	Language(s) Spoken	Written	

Parent / Guardian Information

Mother's Name	First	Middle	Last
Address	City, State, Zip	Home Phone	Cell Phone
Father's Name	First	Middle	Last
Address	City, State, Zip	Home Phone	Cell Phone
Other	First	Middle	Last
Address	City, State, Zip	Home Phone	Cell Phone

Custody (Check One)

Legal	☐ Mother	☐ Father	☐ Joint	☐ Other (specify):
Physical	☐ Mother	☐ Father	☐ Joint	☐ Other (specify):

Please provide a copy of all custody papers.

County Information

Social Worker	First	Last	County
Address	City, State, Zip	Phone	Fax
Probation Officer	First	Last	County
Address	City, State, Zip	Phone	Fax
Guardian Ad Litem	First	Last	County
Address	City, State, Zip	Phone	Fax

Insurance Information

(A copy of each card – front and back – should be attached)

Primary Health Insurance Company		Policy Holder	
Policy Number	Group Number	Phone	Contact
Secondary Health Insurance Company		Policy Holder	
Policy Number	Group Number	Phone	Contact
Dental Insurance Company		Policy Holder	
Policy Number	Group Number	Phone	Contact

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Referral Information

Clinical Information

Current Diagnosis
Axis I
Axis II
Axis III
Axis IV
Axis V

Treating Mental Health Professional	Credentials

Services		Name of Provider	Dates of Services
☐ Outpatient Services ☐ Day Treatment ☐ Group Home	☐ Hospitalization ☐ Residential Treatment ☐ Correctional	Name of Provider	Dates of Services
☐ Outpatient Services ☐ Day Treatment ☐ Group Home	☐ Hospitalization ☐ Residential Treatment ☐ Correctional	Name of Provider	Dates of Services
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☐ Outpatient Services ☐ Day Treatment ☐ Group Home	☐ Hospitalization ☐ Residential Treatment ☐ Correctional	Name of Provider	Dates of Services

Current Medications

Name	Dosage
Name	Dosage
Name	Dosage
Name	Dosage
Name	Dosage
Name	Dosage

Summary of Presenting Symptoms

Educational Information

School Last Attended	School District

Grade	Contact	IEP (If yes attach a copy)
		☐ Yes ☐ No