Volunteers of America MINNESOTA

Omegon Referral Admission Assessment

Client Name:	**Date:**
Male ☐ **Female** ☐ **Other:**	**Referral Source:**
Age: **DOB**:	**Phone:**
Home Address:	**Fax:**
	Email:
Race:	**County:**
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:

Previous chemical abuse/dependencies or dx:

Current meds (need 1 weeks' worth 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 ☐
In need of detox? Yes ☐ No ☐	**Family will participate in program (we require 4 hours family therapy per month and offer parent group twice a month)?** Yes ☐ No ☐

Run risk? Yes ☐ No ☐	**Informed length of stay (3-9 mos.)** Yes ☐ No ☐
If yes, please explain:	
Collateral info requests:	**Psychiatric reports?** Yes ☐ No ☐
Psychological report? Yes ☐ No ☐	**Chemical assessments?** 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 #:**
Omegon Review of Referral (internal use only):	
Date of review:	**Reviewer:**
Other parties involved:	**Contact Information:**
Recommendations/Concerns:	
Omegon Residential Treatment appropriate/needed: Yes ☐ No ☐	
Program able to meeting client's cultural, emotional, educational, mental health, chemical health and physical needs: Yes ☐ No ☐	
If yes, admitting diagnosis: Primary MH ☐ CD ☐	
DSM 5 Dx:	