

## Omegon Referral Admission Assessment

<b>Client Name:</b>		<b>Date:</b>	
<b>Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/> <b>Other:</b> <input type="checkbox"/>		<b>Referral Source:</b>	
<b>Age:</b>	<b>DOB:</b>	<b>Phone:</b>	
<b>Home Address:</b>		<b>Fax:</b>	
		<b>Email:</b>	
<b>Race:</b>		<b>County:</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>	
<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>	
<b>Presenting problems:</b>			
<b>Previous mental health symptoms or dx:</b>			
<b>Previous chemical abuse/dependencies or dx:</b>			
<b>Current meds (need 1 weeks' worth 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>In need of detox?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Family will participate in program (we require 4 hours family therapy per month and offer parent group twice a month)?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	

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