Volunteers of America
MINNESOTA AND WISCONSIN

Avanti ◆ Bar None ShelterPlus ◆ Children's Residential Treatment Center ◆ Omegon

Referral Information Checklist

Please include the following information when making a referral to Avanti, Bar None ShelterPlus, Children's Residential Treatment Center (CRTC), and/or Omegon:

- ☐ Completed Resident Facesheet and Pre-Admission Assessment
- ☐ Relevant legal documentation such as releases of information, custody papers, or court orders
- ☐ Rule 25 Chemical Assessment (required for all referrals to Omegon and/or whenever there is a chemical health diagnosis concern for a chemical health diagnosis)
- ☐ Additional documents and/or signed releases to request the following clinical information (resident signature is required for clients over 16 and for all applications to Omegon):
    - Most recent Psychological/Psychiatric/Diagnostic Assessment
    - Treatment summaries and recommendations (e.g. from hospital stays, day treatment programs, outpatient providers, etc.)

Please note the following: Incomplete applications will not be considered for placement. All areas on the referral form must be complete and all relevant clinical documentation submitted. Additionally, referrals must include formal documentation of the client's status and situation within the three months prior to referral.

Please send completed referral form and documentation to:

Avanti: Tarren Davis
Phone 763-252-4526, Fax 888-972-8981
Email tarren.davis@voamn.org
Address 10300 Flanders St NE, Blaine MN 55449

Bar-None: Sara Ellis
Phone 763-252-4541, Fax 888-965-5125
Email sara.ellis@voamn.org
Address 22426 St. Francis Blvd, Anoka MN 55303

CRTC: Annie O'Hagan
Phone 612-278-4221, Fax 888-965-5129
Email anna.ohagan@voamn.org
Address 2000 Hopkins Crossroad, Minnetonka MN 55305

Omegon: Jennifer Padden
Phone 952-945-4105, Fax 888-965-5128
Email jennifer.padden@voamn.org
Address 22426 St. Francis Blvd, Anoka MN 55303

Prior to admission, the following documents may also be requested:

- ☐ Copies of insurance cards
- ☐ Signed release for county social worker, CPS worker, and/or mental health case manager
- ☐ Most recent Individualized Education Program (IEP), including any testing or assessment done by the school district
- ☐ Additional documents and/or signed releases to request the following clinical information (resident signature is required for clients over 16 and for all applications to Omegon):
    - All previous psychological/neuropsychological testing reports
    - All medical health records, including past and current medications and supplements

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Resident Facesheet and Pre-Admission Assessment

Date:

Client Information				
First name:	**Middle name:**		**Last name:**	
Date of birth:	**Age:**	**Sex:**	**Preferred pronouns:**	**Nickname:**
Address:			**SSN:**	
City:		**State:**	**Zip code:**	
Referral source:			**Place of birth:**	
Child's current location (home, hospital, shelter etc.):			**Languages spoken/written:**	
Identifying characteristics (hair/eye color/tattoos etc.):				
Race/Cultural Heritage/Native American Tribal Affiliation/Religious or spiritual affiliation:				
Mother's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Father's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Other/Guardian's Name:		**DOB:**	**Phone:**	**Contact in an emergency?**
Address:			**Email:**	☐ Yes ☐ No
Is the child adopted? ☐ **Yes** ☐ **No**		**At what age?**		
Legal Custody: ☐ **Mother** ☐ **Father** ☐ **Joint** ☐ **Other (specify):**			**Physical Custody:** ☐ **Mother** ☐ **Father** ☐ **Joint** ☐ **Other (specify):**	
☐ **I have provided a copy of custody paperwork (if applicable).** **(initials)**			**Is this a court ordered placement?** ☐ **Yes** ☐ **No**	
Is anyone restricted from contact with the child? ☐ **Yes** ☐ **No**		**Name:**		**Relation:**
Social Worker Name:			**County:**	**Contact in an emergency?**
Address:			**Phone:**	☐ Yes ☐ No
Email:			**Fax:**	
Probation Officer Name:			**County:**	**Contact in an emergency?**
Address:			**Phone:**	☐ Yes ☐ No
Email:			**Fax:**	
Children's Mental Health Case Manager:			**County:**	**Contact in an emergency?**
Address:			**Phone:**	☐ Yes ☐ No
Email:			**Fax:**	
Rule 25 Funding Authorizer (if applicable):			**County:**	
Address:			**Phone:**	
Email:			**Fax:**	

Insurance Information		
Primary Health Insurance:		**Subscriber name:**
Policy or ID#	**Group:**	**Phone:**
Secondary Health Insurance:		**Subscriber name:**
Policy or ID#	**Group:**	**Phone:**
Financially Responsible Party (parent/guardian/county etc.):		**MA#:**

Office Use Only Below

Client Number/Unit:

Admission Date/Time:

Clinical Coordinator:

Discharge Date:

Diagnosis at Intake:

Clinical Information		
Presenting Problems (what has happened to prompt the search for treatment right now):		
Is this client currently experiencing hallucinations/delusions?		☐ Yes ☐ No
Is this client a danger to self?		☐ Yes ☐ No
Is this client a danger to others?		☐ Yes ☐ No
Is this client at risk of running away from treatment?		☐ Yes ☐ No
Does this client have a history of physically assaulting anyone?		☐ Yes ☐ No
Does this client have a history of property destruction		☐ Yes ☐ No
Does this client have a history of perpetrating sexual abuse?		☐ Yes ☐ No
Does this client have a history of eating disorder behaviors?		☐ Yes ☐ No
☐ Restricting ☐ Purging ☐ Other (please specify):		
If you answered "yes" to any of the above questions, please provide details in the appropriate boxes.		
Client's strengths and assets:		
Goals of Treatment:		
County Case Plan Goals (if applicable):		
Current MH Professional/Therapist:		**Phone:**
Address:		**Fax:**
Current Psychiatrist:		**Phone:**
Address:		**Fax:**
Date and location of most recent psychological/neurological testing:		
Are you seeking psychiatric care/consult/medication management? (Bar None shelter units only): ☐ Yes ☐ No		

Treatment History		
Type of Setting: ☐ **outpatient** ☐ **inpatient** ☐ **hospital** ☐ **day treatment**	**Provider Name:**	**Estimated dates of service:**
Type of Setting: ☐ **outpatient** ☐ **inpatient** ☐ **hospital** ☐ **day treatment**	**Provider Name:**	**Estimated dates of service:**
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Medications/Medical			
Current medications:		**Are any given by injection?**	☐ Yes ☐ No
Prescribing doctor:		**Phone:**	
Address:		**Fax:**	
Has the client had a concussion or TBI?	☐ Yes* ☐ No	***If yes, date:**	

Has the client ever had a seizure? ☐ Yes ☐ No	**On seizure meds?** ☐ Yes ☐ No **Date of last EEG:**	
Does the client have Diabetes? ☐ Yes ☐ No ☐ Type 1 ☐ Type 2	**On diabetes meds?** ☐ Yes ☐ No **Medication name:**	
Has the client broken a bone in the last month?	☐ Yes ☐ No	
Does the client currently have braces on teeth?	☐ Yes ☐ No	
Has the client ever had a positive Mantoux (Tuberculosis) test?	☐ Yes* ☐ No ****If yes, a chest x-ray is required before admission***	
Does the client have any food, animal or drug allergies?	☐ Yes ☐ No **Do they have an epi pen?** ☐ Yes ☐ No	
***List allergies/reactions:**		
Any special dietary requirements?	☐ Yes* ☐ No ***If yes, please explain:**	
Has the client ever had asthma?	☐ Yes* ☐ No ***If yes, last time they needed an inhaler:**	
Any serious, chronic or communicable diseases?	☐ Yes* ☐ No ***If yes, please explain:**	
Any cardiac issues? ☐ Yes* ☐ No	***If yes, please explain:** **Date of last EKG:**	
Does the client have mobility issues? ☐ Yes* ☐ No	***If yes, please explain:**	

Primary Care Physician/Clinic:	**Phone:**
Address:	**Fax:**
Dentist/Dental Clinic:	**Phone:**
Address:	**Fax:**

Last Physical:	**Last Eye Exam:**	**Last Dental:**

Are there any pending or ongoing medical appointments? ☐ Yes ☐ No **Please explain:**

Educational Information

Last school attended:	**Current Grade:**
Address:	**School contact person:**
Home School District:	**IQ:**

Individualized Education Plan (IEP)? ☐ Yes* ☐ No ***If yes, please attach a copy and IEP evaluation for our records**

Legal Information

Is the client court ordered to attend treatment?	☐ Yes* ☐ No ***If yes, please attach a copy of court order.**
Is the client an adjudicated delinquent?	☐ Yes** ☐ No
Does the client have assault charges?	☐ Yes** ☐ No
****Please briefly describe all legal charges or pending charges:**	

Motivation

Does the client believe they have a problem with drugs and/or alcohol?	☐ Yes ☐ No ☐ NA	
Have they had a Rule 25 (Chemical Dependency) evaluation?	☐ Yes ☐ No ☐ NA	
Does the client want help getting sober?	☐ Yes ☐ No ☐ NA	
Does the client know someone is looking into long term treatment for them?	☐ Yes ☐ No	
Does the client know the program's length of stay is at least 3 months?	☐ Yes ☐ No	
Is the family/guardian willing to participate in 4 hours of family therapy a month?	☐ Yes ☐ No	
Does the family/guardian know that the program is not a locked facility?	☐ Yes ☐ No	
Anything else we should know?		

Name of person filling out application:	**Date:**	**Signature:**

For Guardians: On behalf of VOA, we would like to place your child in the most appropriate program. Therefore, we would like your permission to share information between all sites and will determine the most appropriate program for your child/youth based on the information provided.
Do you agree for information to be shared between VOA's residential programs? ☐ Yes ☐ No

Legal Guardian's Name:	**Date:**	**Signature:**

Office Use Only Below

Clinical Review Form

Client Information			
First Name:	**Middle Name:**		**Last Name:**
Date of Birth:	**Age:**	**Sex:**	**Insurance:**
Review			
Current MH Dx:	**Current CD Dx:**		**Primary MH or CD?** ☐ **MH** ☐ **CD** (Omegon only)
Reason for Referral:			
Current Recommendation:			
Strengths:			
Trauma History:			
Initial Concerns (e.g. cognitive functioning, concerning behaviors, etc.):			
Interventions:			
Initial Reviewer:		**Review Date:**	
Reviewer signature:		**Date:**	
Additional Interventions (as needed):			
Is program appropriate/needed:			☐ **Yes** ☐ **No**
Is program able to meet client's cultural, emotional, educational, mental health, chemical and physical needs:			☐ **Yes** ☐ **No**
Final Reviewer:		**Review Date:**	
Reviewer signature:		**Date:**	