

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 Residential Services (Omegon and ShelterPlus): 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

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

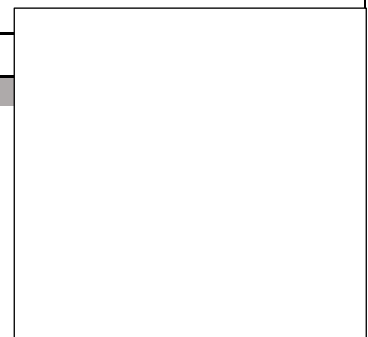
Resident Facesheet and Pre-Admission Assessment

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:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Father's Name:		DOB:	Phone:	Contact in an emergency?	
Address:		Email:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other/Guardian's Name:		DOB:	Phone:	Contact in an emergency?	
Address:		Email:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No At what age?					
Legal Custody: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Joint <input type="checkbox"/> Other (specify):			Physical Custody: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Joint <input type="checkbox"/> Other (specify):		
<input type="checkbox"/> I have provided a copy of custody paperwork (if applicable). (initials)			Is this a court ordered placement? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is anyone restricted from contact with the child? <input type="checkbox"/> Yes <input type="checkbox"/> No			Name:		Relation:
Social Worker Name:		County:		Contact in an emergency?	
Address:		Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:		Fax:			
Probation Officer Name:		County:		Contact in an emergency?	
Address:		Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Email:		Fax:			
Children's Mental Health Case Manager:		County:		Contact in an emergency?	
Address:		Phone:		<input type="checkbox"/> Yes <input type="checkbox"/> 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#:		

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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this client a danger to self?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this client a danger to others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this client at risk of running away from treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this client have a history of physically assaulting anyone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this client have a history of property destruction	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this client have a history of perpetrating sexual abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this client have a history of eating disorder behaviors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Restricting <input type="checkbox"/> Purging <input type="checkbox"/> 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): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Treatment History		
Type of Setting: <input type="checkbox"/> outpatient <input type="checkbox"/> inpatient <input type="checkbox"/> hospital <input type="checkbox"/> day treatment	Provider Name:	Estimated dates of service:
Type of Setting: <input type="checkbox"/> outpatient <input type="checkbox"/> inpatient <input type="checkbox"/> hospital <input type="checkbox"/> day treatment	Provider Name:	Estimated dates of service:
Type of Setting: <input type="checkbox"/> outpatient <input type="checkbox"/> inpatient <input type="checkbox"/> hospital <input type="checkbox"/> day treatment	Provider Name:	Estimated dates of service:
Type of Setting: <input type="checkbox"/> outpatient <input type="checkbox"/> inpatient <input type="checkbox"/> hospital <input type="checkbox"/> day treatment	Provider Name:	Estimated dates of service:
Type of Setting: <input type="checkbox"/> outpatient <input type="checkbox"/> inpatient <input type="checkbox"/> hospital <input type="checkbox"/> day treatment	Provider Name:	Estimated dates of service:
Type of Setting: <input type="checkbox"/> outpatient <input type="checkbox"/> inpatient <input type="checkbox"/> hospital <input type="checkbox"/> day treatment	Provider Name:	Estimated dates of service:
Medications/Medical		
Current medications:	Are any given by injection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prescribing doctor:	Phone:	
Address:	Fax:	
Has the client had a concussion or TBI?	<input type="checkbox"/> Yes* <input type="checkbox"/> No *If yes, date:	

Has the client ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No	On seizure meds? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last EEG:
Does the client have Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	On diabetes meds? <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication name:
Has the client broken a bone in the last month?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the client currently have braces on teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the client ever had a positive Mantoux (Tuberculosis) test?	<input type="checkbox"/> Yes* <input type="checkbox"/> No <i>*If yes, a chest x-ray is required before admission</i>	
Does the client have any food, animal or drug allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do they have an epi pen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*List allergies/reactions:		
Any special dietary requirements?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, please explain:
Has the client ever had asthma?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, last time they needed an inhaler:
Any serious, chronic or communicable diseases?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, please explain:
Any cardiac issues? <input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, please explain: Date of last EKG:	
Does the client have mobility issues? <input type="checkbox"/> Yes* <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:		
Educational Information		
Last school attended:	Current Grade:	
Address:	School contact person:	
Home School District:	IQ:	
Individualized Education Plan (IEP)? <input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, please attach a copy and IEP evaluation for our records	
Legal Information		
Is the client court ordered to attend treatment? <input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, please attach a copy of court order.	
Is the client an adjudicated delinquent?	<input type="checkbox"/> Yes** <input type="checkbox"/> No	
Does the client have assault charges?	<input type="checkbox"/> Yes** <input type="checkbox"/> No	
**Please briefly describe all legal charges or pending charges:		
Motivation		
Does the client believe they have a problem with drugs and/or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Have they had a Rule 25 (Chemical Dependency) evaluation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Does the client want help getting sober?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Does the client know someone is looking into long term treatment for them?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the client know the program's length of stay is at least 5 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the family/guardian willing to participate in 4 hours of family therapy a month?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the family/guardian know that the program is not a locked facility?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> MH <input type="checkbox"/> 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:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is program able to meet client's cultural, emotional, educational, mental health, chemical and physical needs:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Final Reviewer:		Review Date:	
Reviewer signature:		Date:	