***Resident Admission Referral***

**543 Cox Rd. Gastonia, NC, (P) 980.888.0251 (F) 980.888.0308**

Applicant information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Family/Guardian information

Parent/Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street/Apt#) (City) (State) (Zip)

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_ If Guardian is not parent, parent’s name: \_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency (in order):

1. Contact name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_
2. Contact name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_

Education History

Schools attended:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Address)

 Dates of enrollment: From \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Address)

 Dates of enrollment: From \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

Does the Client have an IEP? Yes\_\_ No\_\_ If yes is the IEP current?:\_\_\_\_\_\_\_

Does the Client have a 504 Plan? Yes\_\_ No\_\_ If yes is the 504 Plan current?: \_\_\_\_\_\_\_

Is the Client homebound?: Yes\_\_\_\_ No\_\_\_\_ If yes explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Client currently expelled from his/her previous school? Yes\_\_ No\_\_

If Yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any school behavioral concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Out of Home Placement History

(Begin with the most recent placement)

1. Name of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of care: From \_\_\_\_\_\_ to \_\_\_\_\_\_

 Level of Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Name of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of care: From \_\_\_\_\_\_ to \_\_\_\_\_\_

 Level of Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. Name of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of care: From \_\_\_\_\_\_ to \_\_\_\_\_\_

 Level of Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Name of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates of care: From \_\_\_\_\_\_ to \_\_\_\_\_\_

 Level of Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Medical History

Check one:

* Client has no current medical conditions
* Client has current medical condition(s) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is able to be appropriately cared for in a residential treatment facility with the following treatment and follow-up care.

Any history of seizures?: Yes\_\_\_\_ No\_\_\_\_

If yes, please provide further information as to the type and frequency of the seizures: \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies/Reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunizations up to date: Yes\_\_\_ No\_\_\_ *All immunization records must be up to date and submitted prior to admission.*

Check one:

* Client has no previous medical hospitalizations
* Client has had previous medical hospitalization(s) on this date \_\_\_\_\_\_\_\_ for this reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_ Times taken: \_\_\_\_\_\_\_\_\_\_

 Prescribing Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_

 2. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_ Times taken: \_\_\_\_\_\_\_\_\_\_

 Prescribing Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_

 3. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_ Times taken: \_\_\_\_\_\_\_\_\_\_

 Prescribing Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_

 4. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_ Times taken: \_\_\_\_\_\_\_\_\_\_

 Prescribing Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_

 5. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_ Times taken: \_\_\_\_\_\_\_\_\_\_

 Prescribing Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_

Date of last:

Physical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dental Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_Eye Exam: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

| Physicians Name | Address | Phone number |
| --- | --- | --- |
| Dentist Name | Address | Phone Number |
| Specialists Name | Address | Phone Number |

List all Medical History Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health History and Diagnosis

DSM 5 Diagnosis with Codes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is the client currently receiving any psychological/psychiatric services? Yes\_\_\_No\_\_\_

Therapist Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_

Current Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_

Is there a family history of significant mental health or psychiatric/developmental disabilities to your knowledge? Yes\_\_\_No\_\_\_ If yes please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Strengths/Capabilities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Necessary Supports for Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Criminal History

Does Client have any Criminal History? Yes\_\_\_No\_\_\_ If yes please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the client currently have any DJJ involvement? Yes\_\_\_No\_\_\_ If yes:

Court Counselor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_

*Please attach a copy of any court mandated services and/or conditions*

Additional comments regarding placement or client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Printed name of person completing application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company and Title (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person completing application: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pathways Group Home Staff Only**

Application Received By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Title)

Application received on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Date)

Status of Applicant: \_\_\_\_Accepted \_\_\_\_ Declined \_\_\_\_ Wait Listed \_\_\_\_\_

Person Notified of Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_