Patient Label

Admission Application

DEMOGRAPHICS

Call Date/Time:	Patient Name (First Middle Last):	Date of Birth:	Place of Birth:	Age:

Legal Sex: ☐ M ☐ F	Gender Identity: ☐ M ☐ F ☐Other:	Race:	English: ☐Yes ☐No	Social Security Number:

Address:	City:	State:	Zip:	County:

Legal Guardians:	Relationship:	Preferred Phone #:

Address:☐ Same as patient	City:	State:	Zip:	County:

Email:	Additional Contact Information:

Referral Source/Agency:	Contact Name:	Email Address:	Phone #:

Funding Source (Primary Insurance):	Medical Policy #:	Phone #:

Information Obtained From: ☐ Patient ☐ Parent/Guardian ☐ Referral Clinical ☐ Other Professional ☐ Other:

CURRENT PLACEMENT

☐Home ☐Detention ☐Group Home ☐Therapeutic Foster Care ☐Shelter ☐Residential Treatment ☐Inpatient Acute

Name & Contact:

PRIOR TREATMENT & SERVICES (Mental Health, Intellectual Disabilities, Substance Use, Brain Injury, Behavioral Problems)

Placement/Service	Dates	Level of Care	Successful
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Ever discharged from residential treatment due to dangerous behaviors or noncompliance? ☐Yes ☐No

If yes, please explain:

FUNCTIONING & EDUCATION

Grade Level:	☐ IEP ☐ 504 Review Date:	FSIQ:	Special Education Classification: ☐ASD ☐ED ☐ID ☐SLD ☐OHI

School Name/District:

School Address:

Contact Name:	Phone/Fax:	Email:

ADMISSION CRITERIA

- ☐ Between the ages of 10 and 22
- ☐ Intellectual Disability or Autism Spectrum Disorder with a primary psychiatric diagnosis
- ☐ Escalating pattern of self-injurious or aggressive behaviors
- ☐ Symptoms/behaviors indicative of need for increased intensity and frequency of services and supervision
- ☐ Failure of treatment at lesser level of care
- ☐ Moderate deterioration in level of functioning
- ☐ Medically stable

REQUIRES HIGHER LEVEL REVIEW

- ☐ **NONE**
- ☐ Substance abuse history
- ☐ Anticoagulation treatment
- ☐ Wounds requiring complicated dressings
- ☐ Bleeding disorders
- ☐ Hypertension or Hypotension
- ☐ Infectious Processes
- ☐ Severe neurological deficits
- ☐ Cardiac disorders requiring monitoring
- ☐ Unstable seizure disorder
- ☐ Chest pain of unknown etiology
- ☐ Currently medically unstable/unstable vital signs
- ☐ Probation status – violent offenses
- ☐ Assistive device needs ___________________________
- ☐ Other medical requiring skilled nursing care
- ☐ Significant abnormal labs/EKG
- ☐ Traumatic brain injury
- ☐ Difficulty swallowing
- ☐ Durogesic patch
- ☐ Pica/Intentional swallowing non-food items
- ☐ Former residents
- ☐ Pregnancy

EXCLUSIONARY CRITERIA

- ☐ **NONE**
- ☐ Medically unstable and/or req. intensive medical care beyond the scope of the facility
- ☐ Non-ambulatory
- ☐ Unable to perform ADLs with assistance
- ☐ Under age 10 or over 21
- ☐ Substance Abuse Disorder requiring treatment
- ☐ Active Eating Disorders
- ☐ IQ below 35
- ☐ Complete unwillingness to participate in treatment
- ☐ Recommended for sexual offender treatment program

HISTORY & DIAGNOSIS

Psychiatric & Medical Diagnoses:

Family Medical History – Applicant's Biological Parents and Siblings:

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SOCIAL & DEVELOPMENTAL HISTORY

Available for Family Therapy: ☐Yes ☐No	Parent/Legal Guardian (First Middle Last):	☐DSS ☐Termination of Parental Rights

Preferred Phone:	Secondary Phone:	Email:

Brief Description of Family Relationships:

Developmental Milestone and History:

Mental Health, Emotional, and Psychological Behaviors:

Strengths:

Areas of Concern:

Current Legal Involvement ☐Yes ☐No – If yes, please describe all current and pending charges:

MEDICAL HISTORY

Medications (Prescription & Non Prescription):

Current Medication/Dosage:	Please list any Ineffective Medications:

Please list any additional medications taken over the 6 months prior to admission to include prescription and non-prescription drugs.

Allergies (Food, Drug, or Environmental):

Allergen	Reaction

Nutritional Requirements (Special Diet etc.)

Continence: Enuresis (Wetting): ☐ No ☐ Day ☐ Night	Encopresis (Soiling): ☐ No ☐ Day ☐ Night

Immunization: Submission of full list of current immunizations as required for all school age youth in the Commonwealth of Virginia.

Please attach full list of current immunizations.

Has patient completed all required immunizations? ☐ Yes ☐ No

If no, explain immunization needs: ____

Dental:
Current Dentist:
Phone Number:

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SUBSTANCE ABUSE HISTORY

History of Substance Abuse: ☐Yes ☐No

If yes, please list all names of drugs, including alcohol, and timeline.

Illicit Drugs:	Timeline:
	☐ More than 6 month ☐ Less than 6 month ☐ Other:
	☐ More than 6 month ☐ Less than 6 month ☐ Other:
	☐ More than 6 month ☐ Less than 6 month ☐ Other:

PSYCHIATRIC HISTORY & BEHAVIORS

Psychological Testing: ☐Yes ☐No | Psychiatric Evaluation: ☐Yes ☐No

Trauma: ☐Physical ☐Neglect ☐Sexual ☐Death ☐Other:____

Protection Needs of Patient (i.e. potential victimization, violence, need for supervision, specialized equipment):

Has abuse or neglect ever been reported to Child Protective Services? ☐Yes ☐No

Is DSS/CPS currently involved with family? ☐Yes ☐No
If yes, please explain.

Positive Behavioral Supports needed for applicant:

Behaviors	Frequency	Intensity
☐ Suicidal Ideation/ Attempts	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Homicidal Ideation	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Self-Injurious Behavior	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Fire-Setting	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Cruelty to Animals	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Stealing	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Gang Involvement	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Defiant/Oppositional	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Explosive	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Low Frustration Tolerance	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Impulsive	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Substance Abuse/Use	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Runaway (Actual or Threatened)	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Sexual Acting Out	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Academic Issues	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Destructive	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Aggressive/Injuries Towards Others	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Self-esteem Issues	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Blames Self/Others	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Poor Hygiene	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Social Withdrawal/Isolation	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Anxiety	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Fearfulness/Phobias	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Obsessive/Compulsive/Intrusive Thoughts	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Sadness	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Sleep Disturbances	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Bizarre Thoughts	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Hallucinations or Delusions	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe
☐ Paranoia	☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely	☐ Mild ☐ Moderate ☐ Severe

Please describe current behavioral functioning and social behavioral competence to include any behaviors not listed above:

Discharge Planning Needs and Anticipated Plan: