



407 130th Avenue South • Onamia, MN 56359 • Phone: 320-532-4005 • Fax: 320-532-4898

Referral Form

Date of Referral: _____ Referral Source: _____

YOUTH DEMOGRAPHICS

Youth's Full Name: _____

Date of Birth: _____ Birth Place: _____

Gender: _____ Nickname: _____

Race: _____ Religion: _____

Height: _____ Weight: _____ Age: _____

PLACING AGENCY REFERRAL SOURCE

Name: _____

Agency Address: _____

Phone: _____

Fax: _____

Email: _____

OTHER COUNTY CONTACTS: Guardian Ad Litem, Social Worker, Probation Officer

Name: _____

Agency Address: _____

Phone: _____

Fax: _____

Email: _____

Name: _____

Agency Address: _____

Phone: _____

Fax: _____

Email: _____



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FUNDING INFORMATION

Billing Contact Person: _____

Billing Agency: _____

Billing Address: _____

Phone: _____

Fax: _____

Medicaid Elig: _____ PMI: _____ PMAP: _____ ID: _____

Insurance: _____ ID: _____ GRP: _____

Phone: _____

Fax: _____

Email: _____

REASON(S) FOR PLACEMENT:

Describe the specific incident(s) or behavior(s) that recently occurred to precipitate the need for this referral and previous behaviors of concern:

PREVIOUS PLACEMENT, PSYCHIATRIC AND OTHER SERVICES:

Provider/Agency	Type of Service	Dates of Placement/Service

FAMILY INFORMATION:

Who comprises the youth's "family"? (biological family, foster care family, adoptive family, extended family):

Has the youth been adopted? If so, at what age? _____



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YOUTH'S LEGAL CUSTODIAN

Name: _____

Address: _____

Phone: _____

Email: _____

NAMES OF PARENTS, GUARDIANS, AND FAMILY MEMBERS

Name	Relationship to youth

PRIMARY FAMILY LEGAL ADDRESS

Address: _____

Phone: _____

Email: _____

Fax: _____

Will the family be a resource and involved in treatment? Yes _____ No _____

When was the last time the youth lived with his family? _____

Has the youth experienced a lot of family disruptions? Yes _____ No _____

If YES, please explain (multiple placements, moves, family rights terminated, etc.):



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EDUCATIONAL HISTORY

Current Grade: _____ Last Known IQ: _____ IEP: Yes No

Special Education Classification:

____ Learning Disability

____ Emotional/Behavioral Disability

____ Other

School District/Name of Last School Attended: _____

Contact Person-Name and Title: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Overview of youth's behavior at school:

MEDICAL HISTORY

Are there any current medical issues? Yes _____ No _____

If YES, please explain/list: _____

Any allergies? Yes _____ No _____

If YES, please explain/list: _____

Any physical disabilities? Yes _____ No _____

If YES, please explain/list: _____

Are there any medical or physical restrictions? Yes _____ No _____

If YES, please explain/list: _____

Are there any medical or physical reasons that the youth should not be restrained or held in case of emergency? Yes _____ No _____

If YES, please explain/list: _____



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CURRENT DSM DIAGNOSIS

Code	Diagnosis

Date of last Diagnostic Assessment* completed: _____
 Date of last CASII* (level of care) completed: _____
 Date of last Strength and Difficulties Questionnaire (SDQ)* completed: _____

*Please submit copies of the DA, CASII, and SDQ with this form.

CURRENT MEDICATIONS

Medication	Dose

History of Medications: _____

Is there anything we should know about medications that have been attempted, tried, recommended? _____

LEGAL HISTORY

Is the youth required to register? Yes _____ No _____

If YES, has the youth registered? Yes _____ No _____

Does the youth owe any restitution? Yes _____ No _____

If YES, how much do they owe? \$_____

History of Violent Behaviors? Yes _____ No _____

History of Self Harm in last 6 months? Yes _____ No _____

Current Charges (Please include charges pending): _____

Previous Charges: _____

Please list any cultural or religious considerations: _____



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YOUTH'S STRENGTHS

List the strengths that the youth has (educational/academics, personal interests, achievements, etc.): _____

Name of person completing this form: _____

Signature: _____

Date: _____