



Check which service is being requested:

Long-Term Treatment Short-Term Treatment 45-Day Assessment CIBS Program

Date of Referral: _____ Referral Source: _____

YOUTH INFORMATION

Youth's Full Name: _____

Date of Birth: _____ Birth Place: _____

Gender: _____ Nickname: _____

Race: _____ HT: _____ WT: _____

Religion: _____ Hair Color: _____ Eye Color: _____

of Siblings: _____

Youth's Current Placement: _____

Previous Placements (location & dates): _____

Youth's Primary Reasons for Needing Placement: _____

Psychiatric Diagnosis: _____

Date of Last Diagnostic Assessment: _____

Current Medications: _____

Medical Diagnosis: _____

Allergies: _____

Food Restrictions: _____

Physical Disabilities: _____

Family Doctor: _____

Clinic: _____ Phone: _____

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

School District Name & Number: _____

Contact: _____ Phone: _____

Referring Agency Information

Referral Agent: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Work Cell: _____ Fax: _____

Email: _____

Family Information

Father: _____ Level of Involvement: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

DOB: _____

Mother: _____ Level of Involvement: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

DOB: _____

Funding Information

Funding Agency:_____

Insurance:_____ PMAP:_____ MA:_____ MA number:_____

Name of Insurance Company:_____ Phone:_____

Group#:_____ ID:_____

Name & DOB of Insured:_____

Relationship to Youth:_____

Send your completed form to Loren Nerison, Admissions Supervisor:

email: lnerison@nexusgerard.org

Fax: (507) 434-4433