Aspen House
OPERATED BY NEXUS FAMILY HEALING

# Referral Form

Date of Referral: ________________________

**DEMOGRAPHICS**

Full Name: ____________________________________________________________________________

Nickname: ____________________________________________________________________________

Date of Birth: ________________________________________

Gender Identity: ______________________________________

Address: ______________________________________________________________________________

Phone: _______________________________________ Email: ___________________________________________

**REFERRAL SOURCE**

County of Financial Responsibility:

☐Dakota County

☐Social Services ☐Community Corrections

☐Washington County

☐Community Services ☐ Community Corrections

Contact Person: _______________________________________________________________________

Phone: _______________________________________ Email: ___________________________________________

**INSURANCE INFORMATION (if applicable)**

Billing Contact Person: ______________________________________________________________

Billing Address: _____________________________________________________________________

Phone: ______________________________________________________________________________

Medicaid Eligible: ____________ Insurance: ___________ No Insurance: ___________

GRP: _____________ PMI: _____________ PMAP: ____________ ID: _____________

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**REASONS FOR REFERRAL:**

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

Is the individual in agreement with the decision to come to Aspen House and possibly receive residential placement?
Yes_____ No_____

**Does the individual have:**

Active suicidality? Yes_____ No_____
A current plan for suicide and the means? Yes_____ No_____
If YES, please explain: ______________________________________________
Current homicidal thoughts? Yes_____ No_____
Agitation that would require restraint? Yes_____ No_____
Restraint used in the last 48 hours? Yes_____ No_____
Current elopement behavior? Yes_____ No_____

**SUBSTANCE USE**

Current type of substance use:
______________________________________________
Frequency and duration of use______________________ Risk of withdrawal? __________
Tobacco use? Yes_____ No_____
*Please be advised, Aspen House is smoke and tobacco free; e-cigarettes and vaping devices are prohibited.*

**TRANSPORTATION**

Does the individual have transportation or the ability to get to and from Aspen House? Yes_____ No_____

**PREVIOUS PLACEMENT, PSYCHIATRIC AND OTHER SERVICES** (include prior hospitalizations and short-term crisis stabilization utilization for the past 6 months):

**YOUTH'S LEGAL GUARDIAN/CUSTODIAN**

Name: ______________________________________________
Address: ______________________________________________
Phone: ______________________ Email: ______________________

Is the youth's guardian aware the youth is seeking services? Yes____ No____

**NAMES OF PARENTS, GUARDIANS, AND FAMILY MEMBERS:**

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

| Name | Relationship to Youth |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

***DISCLAIMER:*** *A youth's guardian or legal custodian must provide signatures for the youth to be admitted to Aspen House. No admittance can occur without proper signatures.*

**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: ____________________________________________________________________________

Any medical equipment that would need to be utilized on-site? Yes____ No____

If YES, please explain/list: ____________________________________________________________________________

If YES, do they have access to this equipment to bring with them? Yes____ No____

Does the individual have difficulty providing for their own self-care (bathing, feeding, toileting)?

Yes____ No____

If YES, please explain/list: ____________________________________________________________________________

**CURRENT DSM DIAGNOSIS**

| Code | Diagnosis |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Date of last Diagnostic Assessment completed: ____________________________________________________________

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Has a crisis assessment been completed? __ Yes ___ No (If yes, please send assessment to admin@aspenhouse.org)

**CURRENT MEDICATIONS**

| Medication | Dose |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Does the individual have access to the prescribed medications, and can they bring them with in originally prescribed medication bottles? ___________________________________________________________________________________________

**Staff Use Only**

Time the referral was received:

Time initial call was made to the referral source for decision or request for additional information:

Time staff called for consult (if needed):

Time final disposition was made: