CLIENT DEMOGRAPHIC AND CONTACT INFORMATION

DEMOGRAPHIC INFORMATION

Client Name:____

DOB:___________________________ Admission Date:________________

SSN:___________________________ Medicaid #:____________________

Gender:_________________________ Ethnicity:_____________________

Birthplace:______________________ Religion:______________________

Height:__________________________ Eye Color:____________________

Weight:__________________________ Hair Color:____________________

DSM-IV Diagnosis

Axis I (primary):____

(secondary):____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____

Dates of last appts: Physical _____________ Dental: _______________ Vision: _______________

Medications: ____

____

Allergies: ____

CLIENT CONTACTS:

Legal Guardian:______________________________ Email:__________________________

Relationship: ___________________________ Phone #: ________________________

Address: _______________________________ Alternate # / fax:_________________

Juv. Probation Officer (if applicable): ____

Phone #:________________________

Alternative # /fax:________________

ADM:_________________________________ Phone #:________________________

Fax #:___________________________

Case Manager:__________________________ Phone #:________________________

Fax #:___________________________

DCM Supervisor**:**________________________ Phone:__________________________

Fax #:___________________________

Guardian Ad Litem:_____________________ Phone #:________________________

Fax #:___________________________

Attorney Ad Litem:______________________ Phone #:________________________

Fax #:___________________________

School:_______________________________ Phone #:________________________

Address:______________________________ fax #:__________________________

ESE/Guidance:__________________________ Phone #:________________________

Additional Contacts

Name:_________________________________ Phone #:________________________

Relationship:___________________________ Alternative #:___________________

RESIDENTIAL REFERRAL FORM Page 1 of 2

Client Name:________________________________ Date of Birth:___________________
Referral Source: ____
Person Completing Form:____
Relationship to Client:____

Why is this client being referred for treatment? (e.g., behaviors/symptoms):__________________
____
____
____
____

Describe behaviors and problems:____
____
____
____

Has the client been a victim of emotional, physical or sexual abuse? Describe.________________
____
____
____
____

Describe any history of aggressive, violent or suicidal behavior:____________________________
____
____
____
____

List all prior mental health treatment: ____
____
____
____

Describe any prior sexually reactive behaviors: ____
____
____
____

Room
Restrictions/"Alerts"____

List all current medications: ____
____
____
____
____

Client Name: ______________________
Client SS# ________________________

RESIDENTIAL REFERRAL FORM Page 2 of 2

Describe any history of alcohol/substance abuse: ____
____
____
____
____

Describe any history of thinking problems, hallucinations, delusions, or bizarre behavior: ______
____
____
____

What is the client's current educational grade level? Is the client in special education or in need of any specialized educational services? ____
____
____
____
____

List any medical conditions or special needs: ____
____
____
____
____

List any client interests, special aptitudes, and/or strengths: _______________________________
____
____
____

Additional comments or relevant issues: ____
____
____
____
____

Client Name:______________________________
Medicaid #: ______________________________
Client SS #: ______________________________

Emergency Contacts list for Critical Incidents

Dear guardian,
HomeSafe residential programs have a system in place in which we make immediate notification to all relevant parties, for ALL critical incidents, concerning your client/child. These types of incidents include: Runaways, arrests, Baker Acts, ER visits, Etc. Please provide the names and contact information as to whom we need to contact, regarding any critical incidents.

Legal Guardian__________________________________ Phone #__________________________

Email: ____

ON CALL/CBC reportable Incident #/ETC.
____

Parent: _______________________________________ Phone # ___________________________

Email: ____

SPOA/UM (CBC)________________________________ Phone #
____
____

(Please list other emergency contact numbers such as GAL, TCM, etc. below)

Name/Title	Phone #	Email
	( )	
	( )	
	( )	
	( )	

Note: all critical incident reports will be emailed to the CBC/Circuit within the 24 hour period of occurrence (business days).
Notes:

Client Name: ____________________________________
Medicaid #:_____________________________________
Client SS #: ____________________________________

Approved visitation and Communication List

Incoming and outgoing mail and telephone calls and acceptable for:

Name	Relationship	Supervision required	Phone number
		Yes/No	( )
		Yes/No	( )
		Yes/No	( )
		Yes/No	( )
		Yes/No	( )
		Yes/No	( )
		Yes/No	( )

Visits are approved for:

Name	Relationship	Supervision required	Therapeutic supervision required
		Yes/No	Yes/No
		Yes/No	Yes/No
		Yes/No	Yes/No
		Yes/No	Yes/No
		Yes/No	Yes/No

Restrictions:
____
____
____

I understand that telephone calls and visitation will occur ONLY at scheduled times
Client Signature ___________________________ **Date:** ____________
Guardian Signature ________________________ **Date:** ____________
Witness__________________________________ **Date:**____________