Solnit Children's Center Referral Form

□ **South Campus PRTF**
915 River Road
Middletown, Connecticut 06457
Phone: 860-704-4015
Fax: 860-704-4260

□ **North Campus PRTF**
32 Gardner Street
East Windsor, Connecticut 06088
Phone: 860-292-4000
Fax: 860-292-4066

Date of Referral _____

Referring Person _____ **Referring Facility** _____
Phone # _____ Fax # _____
Fax #_____

Demographic Information (*PLEASE PRINT)*

Youth's name: _____ [ ] male [ ] female

Date of birth: _____ Age: _____ Ethnicity:_____

Youth's Strengths:
_____

Family's Strengths:
_____

Current Placement: _____Admission Date: _____

Events Leading to Current Placement:

_____

_____

SSN: _____ Primary Language: _____

Need for Interpreter: □ Yes □ No

Medicaid ID # _____

Address: _____

City/State/Zip code: _____

Home phone: _____

Emergency Contact (Other than Primary Caregiver):_____

Emergency Contact Phone: _____

	Parent 1	Parent 2
Name		
Relationship to Youth		
Ethnicity		
Languages		
Address		
Home Phone		
Work Phone		

LEGAL GUARDIAN (If other than listed above) Name_____

Relationship to Youth_____ Home #_____
Work # _____

Goal Development and Community Transition

Goal of Admission
_____
_____
_____

Intended plan following PRTF treatment:
_____
_____

What will be the disposition plan for this youth within 120 days?
_____Reunification (if so, with whom)
_____

_____ Therapeutic Foster Care (if so, has documentation been completed)
_____

_____ Residential Treatment (if so, what is the status of the CANS?_____
_____
_____ Group Home (if so, what is the status of the CANS?) _____

What is the youth's future vision for the long term disposition plan?

Home Residential Treatment

Therapeutic Foster Care Group Home

DCF Involvement (if any):

Link Number: _____

DCF Supervisor: _____ Phone: _____

DCF Program Supervisor: _____ Phone: _____

DCF Social Worker/Area office: _____ Phone: _____

ARG:_____ Phone:_____

Fax: _____

Youth DCF Status: OTC Committed Voluntary FWSN Investigation

Protective Services Committed Delinquent Dually Committed

Juvenile Court involvement (if any):

Parole/Probation Officer: _____ Phone: _____

Arrest History and Offense (when and why)

_____

_____

_____

Living Situation (Name/Age/Relationship to member):

_____

_____

_____

Family History, family psychiatric and substance abuse history, domestic violence, current family stressors that may be affecting patient:

_____

_____

_____

Family's role in treatment:

_____

Religious / Cultural Background:

_____

Restrictions / Special Needs based on religious / cultural background (if any):

_____

_____

_____

Insurance information

Name of Primary Insurance Carrier

_____

Case Manager Name and Phone #:

_____

Insurance # Plan/Code# _____

Subscriber DOB: _____

Subscriber's employer_____

Relationship to Insured:_____

Insurance verified: Yes No

Pre-certified for PRTF with (name)_____ Date:_____

Who will be funding the placement?_____

Has Funding been approved/authorization number:_____

Name of Secondary Insurance: _____

What is the main clinical need or focal problem that leads you to request admission to a PRTF?

_____
_____
_____
_____
_____
_____
_____

What are the contributing factors to the main clinical need/focal problem? Please consider factors from multiple life domains including the individual, family, peer, school, and community:

_____
_____
_____
_____
_____
_____
_____
_____

Current Diagnosis:

Axis I: _____

_____

Axis II:

_____

_____

Axis III:

_____

_____

Axis IV:

_____

_____

Axis V:

_____

_____

Current Medications and Dosages: Note if medication is psychotropic or medical

Name of Medication	Dose	Schedule	Prescribing MD	Target Symptoms/Behaviors

Past Medication Trials: Note if medication is psychotropic or medical

Name of Medication	Dose	Schedule	Prescribing MD	Target Symptoms/Behaviors

Were any medications discontinued due to adverse reactions? If so, which?

_____

_____

_____

Primary Care Physician: _____ Phone: _____

Allergies:_____
_____
_____

Medical Issues- Significant medical history, hospitalizations?

_____
_____
_____

Recent Testing/EKG/EEG/Cat scan? If yes, when? Any abnormalities?

_____
_____

Identify any potential risk factors that may interact with medications:

_____
_____
_____

Any medical conditions that might impact during use of restraint:

_____
_____

Check all that apply:

____ Birth complications ____ Head trauma ____ GI disease ____ Seizures ____ Asthma
____ Cardiac ____ Thyroid disease ____ Diabetes ____ HIV / AIDS

Date of Last Restraint: _____ Reason: _____

Date of Last Seclusion _____ Reason: _____

Date of Last PRN: _____ Reason: _____

Has the youth experienced any of the following? (Please circle one response)

Aggressive behavior	(current/past/unknown/NA)
Homicidal threats	(current/past/unknown/NA)
Anxiety / panic attacks	(current/past/unknown/NA)
Impulsive behavior	(current/past/unknown/NA)
Attention deficit disorder	(current/past/unknown/NA)
Juvenile Court Involvement	(current/past/unknown/NA)
Depression	(current /past/unknown/ NA)
Oppositional behavior	(current/past/unknown/NA)
Dissociative Features	(current/past/unknown/NA)
Run Away	(current/past/unknown/ NA)
Eating Patterns/Concerns	(current/past/unknown/NA)
School problems	(current/past/unknown/ NA)
Fire setting	(current/past/unknown/ NA)
Self Injurious Behaviors	(current/past/unknown/NA)
Hallucinations-Auditory	(current/past/unknown/NA)
Sexualized behavior	(current/past/unknown/NA)
Hallucinations-Visual	(current/past/unknown/NA)
Sleep problems	(current/past/unknown/NA)
History of cruelty to animals	(current/past/unknown/NA)
Suicidal attempts	(current/past/unknown/NA)
Suicidal ideation	(current/past/unknown/NA)

Trauma history/abuse (current/past/unknown/NA) - If yes, please explain when and by whom:

_____

_____

_____

Has youth ever received any of the following services? (if so, please identify where/when)

Psychiatric hospitalization	yes/no/unknown
Substance abuse treatment	yes/no/unknown
IICAPS/FST (other in home services_____)	yes/no/unknown
Outpatient treatment	yes/no/unknown
Partial hospital program	yes/no/unknown
Residential treatment center	yes/no/unknown
Psycho-sexual evaluation	yes/no/unknown
Psychological testing	yes/no/unknown
Other	yes/no/unknown

- Evaluations, discharge summaries, IEP and testing materials should accompany this referral

School Performance

Youth's Current Grade Level: _____
Current School/Town: _____

Special Education Classification? Yes No IQ Testing Date:

IQ Scores: _____

Last PPT: _____

Current Service Providers (Name, Agency, Phone, Service Provided & Dates of Participation):

_____
_____
_____
_____
_____

Does the youth require a single room? If yes, state reason:

_____
_____
_____

Previous experience with roommates:

_____
_____
_____

Signature/Title of Referring Person_____
Date _____

Admissions:

Date of Pre-placement (individual/family) if appropriate: _____

Date of Admission: _____

Assigned Therapist: _____

Assigned Psychiatrist: _____