# Referral Form

CAMBIA HILLS
A MENTAL HEALTH PROGRAM OF WOODLAND HILLS

Referral to which program? ☐ Residential Treatment ☐ Day Treatment

Please complete this form to the best of your knowledge and return to the Admissions Office:

Fax: 218.728.7501 / E-mail: admissions@woodlandhills.org / Phone: 218.728.7500 ext. 141

You will be contacted within one business day to verify receipt of your referral. Thank you for choosing Cambia Hills!

## Child's Information

| | | | | |
|---|---|---|---|---|
| Full Name | Nickname | | Gender ☐ Male ☐ Female | |
| Date of Birth | Place of Birth | | Social Security No. | |
| Last Known or Permanent Address | City | | State | Zip |
| Home Phone | Current Placement or location | | Height | Weight |
| Race/Ethnicity | Primary Language | | Spiritual or religious affiliation | |
| Tribal Affiliation, if any | Is child adopted? | Age at first adoption? | # finalized adoptions? | Is child a State Ward? |
| Medical Insurance Provider and Policy No. | | | | |
| Legal Status of Placement ☐ Delinquency ☐ CHIPS ☐ Voluntary ☐ Not applicable | | | Judge's Name (if applicable) | |
| Date and Time of Court Hearing (if applicable) | Court File No. (if applicable) | | | |

## Child's Profile

| |
|---|
| What are the presenting problems that led to requiring an out-of-home placement? |
| What is the history of or contributing factors to the child's problems? |
| What are some of the child's assets, strengths, interests or abilities? |

## Child's Profile (cont'd)

List child's current medications.

Any health concerns or physical limitations?

☐ Yes ☐ No If yes, explain:

Any cognitive, developmental, or IQ concerns?

☐ Yes ☐ No If yes, explain:

Any school-related problems

☐ Yes ☐ No If yes, explain:

Currently suicidal? Any history of suicide or self-harm? Any hospitalizations for mental health?

☐ Yes ☐ No If yes, explain:

Any chemical abuse? Any treatment interventions?

☐ Yes ☐ No If yes, explain:

Any history of abuse, neglect, or trauma?

☐ Yes ☐ No If yes, explain:

Any safety concerns of child being vulnerable with his/her peers?

☐ Yes ☐ No If yes, explain:

Any history of this child victimizing or harming others?

☐ Yes ☐ No If yes, explain:

Is he/she considered a flight risk?

☐ Yes ☐ No If yes, explain:

## History of Services Delivered

Outpatient Services (therapy, day treatment, etc.)

| Name of Agency | Dates of Service | Result |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Residential/Inpatient Services

| Name of Agency | Dates of Service | Result |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Delinquency History? ☐ Yes ☐ No

| Current and Prior Offenses | Class/Degree of Offense | Offense Date | Disposition |
|---|---|---|---|
| | | | |

## Services You Are Requesting

What treatment goals do you have for your child (or client)?

What additional services does your child/client need?

What is the post-placement plan?

## Contact Information

**Parent/guardian**

| | | | |
|---|---|---|---|
| (1) Parent/Guardian name | Parent's Date of Birth | Does child live with this parent? ☐Yes ☐No | |
| Street Address | City | State | Zip |
| Home Phone | Work Phone | Cell Phone | |
| (2) Parent/Guardian name | Parent's Date of Birth | Does child lives with this parent? ☐Yes ☐No | |
| Street Address | City | State | Zip |
| Home Phone | Work Phone | Cell Phone | |

Who has custody of the child?

Any restrictions on either parent's involvement?

☐Yes ☐No If yes, what?

Will the parent(s/guardian(s be supportive of and/or involved with this placement?

☐Yes ☐No If no, why?

Any additional details we should know regarding custody/contact/visitation, etc.?

## Contact Information (cont'd)

Lead Worker (if this is a private placement by parent or family, check here: ☐ and go to next section of referral

| Referring agency | Worker's name | Phone | |
|---|---|---|---|
| Street address | City | State | Zip |
| E-mail | Cell | Fax | |

| Other Professionals Currently Working with this Child | | | |
|---|---|---|---|
| Agency | Worker's Name | Phone | Involved in treatment? ☐ Yes ☐ No |
| Agency | Worker's Name | Phone | Involved in treatment? ☐ Yes ☐ No |
| Agency | Worker's Name | Phone | Involved in treatment? ☐ Yes ☐ No |
| Agency | Worker's Name | Phone | Involved in treatment? ☐ Yes ☐ No |

| Current School | | |
|---|---|---|
| Name of Current School (not district): | School Contact for this Child: | Phone |
| Child's current grade level? | Does the client have an IEP? (please send) ☐ Yes ☐ No | If yes, primary disability? |

## Supporting Documentation to be Provided (as available/applicable)

Supporting documentation is needed to help us make an informed decision on how we can best meet your child's needs. In general, documentation from a licensed mental health professional that includes a history, diagnosis, family/social information and a recommendation to the appropriate level of care (residential treatment mental health or day treatment) is needed. This is usually found in a standard diagnostic assessment or psychological evaluation. This information must be current (within 6 months for the residential treatment mental health program; within 1 year for day treatment). The more supporting information you are able to send, the better. Supporting information is needed in order for the referral to be reviewed. Please note that you may be asked to sign a release of information for other agencies to share documentation with us.

| | |
|---|---|
| ☐ Psychological or Diagnostic Assessments | ☐ Individual Education Plan (IEP) |
| ☐ Psychiatric Reports | ☐ Program/Hospital Discharge Reports |
| ☐ Social/Family Assessments | ☐ Substance Abuse Assessment (Rule 25) – Most Recent |
| ☐ Court Reports | ☐ Copy of Out-of-Home Placement Plan |
| ☐ Copy of Court Orders | ☐ Voluntary Placement Agreement |
| ☐ CASII or YLSI assessment | ☐ Other: |

Use this space for any additional information you wish to share.