



Referral Form

Referral to which program?

Chisholm 30—*Length of stay (30 days or less):* _____ *days*
 Residential Treatment—*Length of stay (over 30 days):* _____ *days/months*
 Community Transition

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. 143

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

Client's Information

Full Name		Nickname		Gender	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age at first adoption?	# finalized adoptions?	Is child a State Ward? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Insurance Provider and Policy No. Primary:			Secondary:		
Legal Status of Placement				Judge's Name (if applicable)	
Date and Time of Court Hearing (if applicable)		Court File No. (if applicable)			

Client'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 client's problems?

What are some of the child's assets, strengths, interests or abilities?

Client's Profile (cont'd)

List client'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 client being vulnerable with his/her peers?

Yes No If yes, explain:

Any history of this client victimizing or harming others?

Yes No If yes, explain:

Is he/she considered a flight risk?

Yes No If yes, explain:

Current/Most Recent Diagnosis:

Axis I:

Axis II:

Date of Assessment:

History of Services Delivered

Outpatient Services (CD treatment, 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 client?

What additional services does your client need?

What is the post-placement plan?

Contact Information

Parent/guardian

(1) Parent/Guardian name	Parent's Date of Birth	Does child lives with this parent? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	

Who has custody of the client?

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agency	Worker's Name	Phone	Involved in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agency	Worker's Name	Phone	Involved in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Agency	Worker's Name	Phone	Involved in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, primary disability?

Supporting Documentation to be Provided (as available/applicable)

Supporting information is needed in order for the referral to be reviewed. Please fax to 218.728.7501 or email to admissions@woodlandhills.org

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| <input type="checkbox"/> Psychological or Diagnostic Assessments
<input type="checkbox"/> Court Reports (to include Certification Study if applicable)
<input type="checkbox"/> Copy of Court Order
<input type="checkbox"/> Copy of Out-of-Home Placement Plan
<input type="checkbox"/> Substance Abuse Assessment (Rule 25) – Most Recent
<input type="checkbox"/> Individual Education Plan (IEP) | <input type="checkbox"/> Program/Hospital Discharge Reports
<input type="checkbox"/> Voluntary Placement Agreement
<input type="checkbox"/> YLSI assessment
<input type="checkbox"/> Psychiatric Reports
<input type="checkbox"/> Social/Family Assessments
<input type="checkbox"/> Other: |
|---|--|

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