Referral Form

Referral to which program?	☐ Chisholm 30 (Short-Term)—*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@TheHillsYFS.org / **Phone**: 218.623.6428

You will be contacted within one business day to verify receipt of your referral.

Thank you for choosing Woodland Hills, a program of The Hills Youth and Family Services!

Client's Information

Full Name	Nickname		Gender ☐ Male ☐ Female Identifies As ☐ 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? ☐ Yes ☐ No	Age at first adoption?	# finalized adoptions?	Is child a State Ward? ☐ Yes ☐ No
Medical Insurance Provider and Policy No. Primary:		Secondary:		
Legal Status of Placement ☐ Delinquency ☐ EJJ ☐ CHIPS ☐ Voluntary ☐ Not applicable			Gang Affiliation (if applicable)	
Date and Time of Court Hearing (if applicable)	Court File No. (if applicable)		Judge's Name (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 (continued)

Is there a history of sexually offending? If yes, explain.

Please 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? ☐ 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 client?

Any restrictions on either parent's involvement?

☐ Yes ☐ No If yes, what?

Will the parents/guardians) 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 1	Email	Phone	Involved in treatment? ☐ Yes ☐ No
Worker's Name	Address	City, State Zip	
Agency 2	Email	Phone	Involved in treatment? ☐ Yes ☐ No
Worker's Name	Address	City, State Zip	
Agency 3	Email	Phone	Involved in treatment? ☐ Yes ☐ No
Worker's Name	Address	City, State Zip	

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

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

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