School Year _____

Minnewaska W.I.N. Academy Mental Health Services

Day Treatment & Intensive Outpatient Referral

CHILD INFORMATION

Full Name _____ Grade _____ Sex: ☐ Male ☐ Female

Date of Birth _____ Home District _____ SSN _____

CURRENT LIVING SITUATION

☐ Two-parent biological family
☐ One-parent biological family
☐ Two-parent adoptive family
☐ One-parent adoptive family
☐ Foster Care
☐ Therapeutic Foster Care
☐ Group Home
☐ Juvenile facility
☐ Kinship Foster Care
☐ Relatives Home
☐ Psychiatric Inpatient Care
☐ Crisis Residence
☐ Shelter Care
☐ Day Treatment Program
☐ Residential Treatment Center
☐ Other (describe) _____

REFERRAL SOURCE IDENTIFICATION

Date of Referral _____ Organization Name _____

Referral Organization Affiliation:

☐ Mental Health
☐ Juvenile Justice
☐ Social Services
☐ MR/Dev. Disabilities
☐ Education
☐ Court
☐ Medical
☐ Substance Abuse
☐ Child-Care Agency
☐ Crisis Residence
☐ Community Agency
☐ Other (describe) _____

Name of Person Making Referral _____

Phone _____ Email _____

Street Address _____

City _____ Zip _____

FAMILY INFORMATION

Parent(s)/Guardian(s) #1

First Name _____ Last Name _____

Cell Phone _____ Work Phone _____

Email _____ Relationship to Child _____

Parent(s)/Guardian(s) #2

First Name _____ Last Name _____

Cell Phone _____ Work Phone _____

Email _____ Relationship to Child _____

Primary language of family spoken at home:

☐ English ☐ Spanish ☐ American Sign Language ☐ Other (describe) _____

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RACE/ETHNIC IDENTITY

- ☐ White
- ☐ Black/African American
- ☐ Mexican, Mex-Am, Chicano
- ☐ Dominican
- ☐ Asian/Pacific Islander
- ☐ Puerto Rican
- ☐ Central American
- ☐ American Indian
- ☐ Cuban
- ☐ Other (describe) _____

CUSTODY STATUS

- ☐ Two biological parents OR one biological parent and one step-parent
- ☐ Biological mother only
- ☐ Biological father only
- ☐ Relatives
- ☐ Adoptive parent(s)
- ☐ Foster parent(s)
- ☐ Friends (adult friend)
- ☐ State Guardianship
- ☐ Other (describe) _____

FAMILY HISTORY

	YES	NO	UNKNOWN
Is there a history of domestic violence/spousal abuse in child's biological family?	☐	☐	☐
Is there a history of mental illness in child's biological family?	☐	☐	☐
Is there a history of substance abuse in child's biological family?	☐	☐	☐
Does child's current family experience domestic violence/spousal abuse?	☐	☐	☐
Does child's current parent/caretaker have mental illness?	☐	☐	☐
Does child current parent/caretaker have substance abuse issues?	☐	☐	☐

INSURANCE INFORMATION

Type of health coverage:

☐ No insurance ☐ Medicaid (ID #) _____ ☐ Application Pending

☐ Medicaid Managed Care Provider (ID #) _____ ☐ Private, third party coverage

☐ Ineligible ☐ Other (describe)_____

CHILD'S INFORMATION

Does child meet eligibility criteria for Serious Emotional Disturbance: ☐ Yes ☐ No

DSM-IV Diagnosis, if known (Please write diagnosis)

_____

_____

_____

_____

Date of Diagnostic Evaluation_____ Person Making Diagnosis _____

IQ Score (if known): Verbal _____ Performance _____ Full Scale _____ Test Date _____

School Year _____

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PSYCHIATRIC HOSPITALIZATION HISTORY

Please provide as much information that is known.

Number of previous hospitalizations _____ ☐ Unknown

Please list all hospitalizations (if known)

NAME OF HOSPITAL	ADMISSION DATE	DISCHARGE DATE	DAYS HOSPITALIZED

Does child take medication for their mental health?: ☐ Yes ☐ No ☐ Unknown

If yes, list current medication(s) _____

TRAUMA HISTORY

	YES	NO	UNKNOWN
Has child ever been physically abused?	☐	☐	☐
Has child experienced emotional abuse?	☐	☐	☐
Has child ever been sexually abused?	☐	☐	☐

CHILD/FAMILY SERVICE SUPPORT INFORMATION

List services child/family receiving (mental health, probation, child-welfare, other community services

☐ Child Protective Services (CPS) Worker _____ Phone _____

☐ Children's Mental Health Worker _____ Phone _____

☐ Probation Officer _____ Phone _____

☐ Mental Health Outpatient Clinic Agency _____ Phone _____

Worker _____

☐ Other Agency _____ Phone _____

Worker _____

☐ Other Agency _____ Phone _____

Worker _____

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REFERRAL CONCERNS

Screener should consider a child's age, developmental and intellectual level and overall functioning in identifying problems. Check the 2nd column if the problem has been observed within the last month. Check the 3rd column if the problem has ever been observed. Both columns can be checked or left blank.

CHILD'S PROBLEMS	IN LAST MONTH	EVER
1. Excessive irritability	☐	☐
2. Overly sensitive to environment (noise, touch) which causes distress	☐	☐
3. Excessive sadness, crying, withdrawal	☐	☐
4. Excessive fears or worries, difficulty separating from parents, school refusal	☐	☐
5. Recurrent intrusive thoughts or senseless repetitive behaviors, such as hand washing, lock checking, organizing objects	☐	☐
6. Suicidal thoughts, threats, gestures or attempts	☐	☐
7. Hallucinations (sees or hears things that aren't there), delusions (has strong beliefs which have no basis in reality)	☐	☐
8. Difficulty in concentration	☐	☐
9. Irregular or problematic sleep patterns	☐	☐
10. Many nightmares	☐	☐
11. Irregular or problematic eating/appetite patterns	☐	☐
12. Problems in activity patterns (over-active or under-active)	☐	☐
13. Injures self, e.g., cutting , head-banging	☐	☐
14. Enuresis or Encopresis (wetting or soiling)	☐	☐
15. Inability to give or receive appropriate affection to primary caregivers	☐	☐
16. Inability to accept appropriate limits	☐	☐
17. Easily angered or excessive anger or other strong emotion.	☐	☐
18. Frequent, intense, uncontrollable temper tantrums	☐	☐
19. Verbally threatening	☐	☐
20. Physically violent	☐	☐
21. Cruel to animals	☐	☐
22. Willful destruction of property	☐	☐
23. Fire setting	☐	☐
24. Sexually preoccupied or inappropriate sexual activity	☐	☐
25. Running away	☐	☐
26. Suspected or confirmed abuse of alcohol or other drugs/substances	☐	☐
27. Adolescent's pregnancy is/was related to behavioral/emotional difficulties	☐	☐
28. Parenting (Youth is having trouble parenting his/her child(ren)	☐	☐
29. Medical condition complicated by emotional disturbance or medical noncompliance	☐	☐

School Year _____

Day Treatment & Intensive Outpatient Referral

REFERRAL CONCERNS CONTINUED

CHILD'S PROBLEMS	IN LAST MONTH	EVER
30. Persistent unrealistic worry over physical health	☐	☐
31. Problems in school/vocational activity (attendance, behavior, learning, performance)	☐	☐
32. Suspected or confirmed victim of physical, sexual or emotional abuse	☐	☐
33. Problems in interpersonal relationships (family and/or authority figures)	☐	☐
34. Problems in interpersonal relationships (same age peers)	☐	☐
35. Confirmed or suspected developmental delay	☐	☐
36. Arrested, detained, or on probation	☐	☐
37. Homicidal	☐	☐
38. Gambling	☐	☐
39. Avoids people, places or things	☐	☐
40. Always seems jumpy or afraid	☐	☐
41. Gets upset when remembering bad thing that have happened to him/her.	☐	☐

PROVIDE INFORMATION ABOUT THREE BEHAVIORS OR CONCERNS THAT PROMPTED THIS REFERRAL

Behavior or concern #1

Behavior or concern #2

Behavior or concern #3

School Year _____

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CURRENT EDUCATION PLACEMENT AND INFORMATION

☐ Regular class in age appropriate grade
☐ Regular class, retained at grade level _____
☐ Special education-in-district program/service
☐ Day treatment-out-of-district
☐ Pre-school
☐ Vocational training only
☐ Not enrolled in school
☐ High school graduate/GED
☐ Home instruction
☐ Other (describe) _____

Percent of day in setting III or a federal setting V-VIII (Residential, Homebound, Hospital) _____

School District _____ Name of School _____ Grade _____

Special Education Case Manager _____ Phone _____ Email _____

District Representative _____ Phone _____ Email _____

SPECIAL EDUCATION CLASSIFICATION (IF KNOWN)

☐ Emotionally & Behaviorally Disorder
☐ Learning Disabled
☐ Hearing Impaired
☐ Physically Disabled
☐ Other Health Disability
☐ Multiple Handicapped
☐ Pre-School Special Education
☐ Unknown

OTHER SCHOOL BEHAVIORS AND CONCERNS

☐ Truancy/attendance
☐ Failing grades
☐ Frequent suspensions
☐ Poor peer interaction
☐ Poor teacher interaction
☐ Physical aggression
☐ Other (describe) _____

Number of Out of School Suspension _____ Number of In School Suspension _____

Number of restrictive procedures in the current school year _____

ACADEMIC DATA

READING

Estimated Grade Level _____

Skill Deficits _____

Skill Strengths _____

Current MCA Test Results: Score_____ ☐ Did Not Meet ☐ Partially Met ☐ Met

Current Coursework (Curriculum) _____

MATH

Estimated Grade Level _____

Skill Deficits _____

Skill Strengths _____

Current MCA Test Results: Score_____ ☐ Did Not Meet ☐ Partially Met ☐ Met

Current Coursework (Curriculum) _____

School Year _____

Minnewaska W.I.N. Academy Mental Health Services

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STRENGTHS

Please indicate the family's strengths that may be utilized to assist the child with services

Please list child's strengths, interests, hobbies, activities

PLEASE COMPLETE AND ATTACH THE FOLLOWING:

- ☐ Current signed copy of release of information for educational records at residential treatment center/hospital.
- ☐ Current signed copy of release of information between referring district and Minnewaska Area W.I.N. Academy
- ☐ Obtain education records from residential treatment center/hospital.
- ☐ Current signed copy of release of information for diagnostic assessment.
- ☐ Current signed copy of release of information for county worker/social worker.
- ☐ Updated High School Transcript from home district and treatment center/hospital.
- ☐ Immunization Records
- ☐ Current Evaluation Report(not due within the next 6 months)
- ☐ Behavior Intervention Plan
- ☐ Current IEP with any amendments and updated Present Level(s) of Academic Achievement and Functional Performance.
- ☐ Current Prior Written Notice proposing a setting IV placement at Minnewaska Area W.I.N. Academy with mental health services. There needs to be a statement on why W.I.N. Academy is the least restrictive setting and other options considered.
- ☐ Pending acceptance into Minnewaska Area W.I.N. Academy the IEP Service Times need to be reflected prior to starting.

Service	Location	Frequency	Indirect	Direct
Primary Disability	Special Education Classroom	5x week	10	360