NORTH HOMES
Children and Family Services

Today's Date:

Date Placement Needed By:

Referral

All information contained in this placement referral is strictly confidential. Please fax to ensure continued confidentiality.

Youth Name *(First, Middle, Last)*	☐ M ☐ F	**DOB:** **Age:**
Type of Referral:	☐ 35 Day Evaluation ☐ Stabilization/90 Day Intensive Treatment ☐ Secure Detention ☐ Professional Foster Care ☐ Residential Treatment Cottage or Girls residential treatment ☐ Boys Program ☐ Boys Teens In Transition ☐ SEY program	
Youth S.S. Number:	**Race:**	If applicable, **Tribe:**
Youth's Current Residence:		

INFORMATION

Referral Source Name:			
Title:	☐ SW County	☐ CMH	County
	☐ PO County	☐ Parent	Custody Type
	☐ TW Tribe	☐ Other:	

Referral Contact Information

Direct Line: Mailing Address:

Cell: Email Address:

Fax:

Type of Placement: ☐ Court Order ☐ Social Service ☐ Voluntary ☐ Other:

A copy of the hold/placement agreement will be required upon placement. This includes ICPC paperwork.

FAMILY INFO:	ADOPTIVE/ BIO/STEP	MAILING ADDRESS	DATE OF BIRTH	
Father				Has Custody ☐
Full Name:		Home Phone:	Cell Phone:	TPR: ☐ Yes ☐ No ☐ In Process
Mother				Has Custody ☐
Full Name:		Home Phone:	Cell Phone:	TPR: ☐ Yes ☐ No ☐ In Process
Siblings	☐ M ☐ F			Limits to contact
	☐ M ☐ F			Limits to contact
	☐ M ☐ F			Limits to contact
	☐ M ☐ F			Limits to contact

Are there any restrictions on either parent's involvement? If so, please indicate here:

Referral Source Narrative:

Youth's Previous Placements		
Year	Reason	Agency / Location
Has youth received previous services from NHCFS in either Bemidji or Duluth locations? If yes, indicate below. ☐ Yes ☐ No		
Youth's Previous Offenses		
Year	Offense (also explain the original charges if you are on probation)	Outcome

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Name of Current Pharmacy:	Pharmacy Phone Number:		
Name of Drug	Strength / Mg	Frequency Taken	Name of Prescriber & Clinic Associated With

Allergies	
To	Reaction Had

HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.						
Abuse History	☐ Neglect	Perpetrator(s):				
	☐ Physical	Perpetrator(s):				
	☐ Emotional/Psychological	Perpetrator(s):				
	☐ Sexual	Perpetrator(s):				
Risk of Harm to Self	Is there a history of cutting or self injurious behavior (SIB)?				☐ Yes	☐ No
	Is there a history of suicidal ideation?				☐ Yes	☐ No
	# of suicide attempts?					
	Current risk of suicide	☐ Hi	☐ Med	☐ Low		
FASD	☐ None	☐ Suspected	☐ Requesting Diagnosis	☐ Has Diagnosis		
	If diagnosed, name of Diagnostic Clinic/Professional?					
Risk of Harm to Others	History of Sexual Behaviors or Talk?				☐ Yes	☐ No
	If yes, please describe?					
	Has the youth successfully completed treatment to address the behaviors/talk?					
	History of cruelty to animals?				☐ Yes	☐ No
	Verbally abusive to others?				☐ Yes	☐ No
	Physically abusive to others?				☐ Yes	☐ No
	Gang involvement?				☐ Yes	☐ No
	Difficulties with peer relationships?				☐ Yes	☐ No

Run Risk	History of running away?			☐ Yes	☐ No
	☐ Recent – time gone:	☐ months ago:	☐ years ago:	☐ N/A:	
	# of runs:	Places youth goes:			
Homelessness	Does the youth have a history of being homeless?			☐ Yes	☐ No
Drugs / Alcohol	Does youth currently use recreational or street drugs?			☐ Yes	☐ No
	Does youth currently use alcohol?			☐ Yes	☐ No
Mental Health	Does the youth have an eating disorder or suspected eating disorder?			☐ Yes	☐ No
	Does the youth have grief or loss suffering?			☐ Yes	☐ No
	If so, describe loss and month/season it occurred:				
	Does the youth have difficulty with parental relationships?			☐ Yes	☐ No
Additional Questions	Lying or Cheating concerns?			☐ Yes	☐ No
	Enuresis or Encopresis history/current concern?			☐ Yes	☐ No
	Does the youth have vision or hearing loss?			☐ Yes	☐ No
	Does the youth have history of gang involvement?			☐ Yes	☐ No
	Is there a history or concern of truancy or lack of academic motivation?			☐ Yes	☐ No
	Does the youth have identity issues?			☐ Yes	☐ No

Is there a current diagnostic/functional assessment? ☐ Yes ☐ No Date: Clinic/Doctor:	
Specific goals for the youth to accomplish: Last School Attended:	Is youth on an IEP? ☐ Yes ☐ No Grade:
Strengths of youth/family:	
Physical restrictions for the youth: The developmental, educational, cultural, and mental health needs can be met by the program: ☐ Yes ☐ No	
Primary Physician and Dentist – Please provide Name of Clinic, Physician, Dentist and Phone#:	

INSURANCE INFORMATION - A Copy of Insurance card is required				
Name of Primary Insurance:				
Is this a PMAP?			☐ Yes	☐ No
Has the placement been approved by the PMAP?			☐ Yes	☐ No
Have you requested a faxed confirmation?			☐ Yes	☐ No
Address of Insurance:	Telephone number:			
Name of Insured:	Relationship to Youth:	Insured DOB:		
Insured ID Number:	Group Number:	Name of Insured Employer:		
Is there a Secondary Insurance?			☐ Yes	☐ No
Name of Secondary Insurance:				
Address of Insurance:	Telephone number:			
Name of Insured:	Relationship to Youth:	Insured DOB:		
Insured ID Number:	Group Number:	Name of Insured Employer:		

REQUESTED ADDITIONAL SERVICE		
Additional services requested. Specific information can be added in the space provided.		
☐ Psychological Diagnostic:	☐ Family Assessment:	☐ Medication Management:
☐ Psychiatric Diagnostic:	☐ Individual Therapy:	☐ Specific Medical/Dental Care:
☐ Rule 25 and/or CD Care:	☐ Family Therapy:	☐ Other:
☐ CTSS/MHBA:	☐ Adoption Services:	☐ Religious / Cultural Needs:
☐ Free at Last / Evergreen:	☐ Community Service Hours:	☐ Driver's Training: