

SUNNYBROOK CHILDREN'S HOME

Brief Referral Screening

Please fax to: Sharon Kendrick

601.856.6520 Fax/601.856.6555 ext. 107

Date: ___/___/___ Person Referring the Youth: _____ County: _____

_____ DHS Placement _____ Private Placement/Medicaid # _____

Phone: (W): () - _____ - _____ Other _____ () - _____ - _____

(Fax): () - _____ - _____ Email: _____

YOUTH'S NAME: _____

Age: _____ Date of Birth: _____ Gender: ___ Male ___ Female

Length of stay at Sunnybrook Children's Home(SCH) (factors affecting placement) _____

Education History: Grade _____ Special Education Requirements _____

School disciplinary problems _____

If checked "Yes" please give details

Yes No History of sexual, physical, emotional abuse _____

Yes No Physical/Verbal aggression (i.e. hitting, throwing things, threatening, yelling, etc.) _____

Yes No Sexual offending/ Sexual acting out _____

Yes No Suicide attempts/thoughts _____

Yes No Involvement with the Police/juvenile detention _____

Yes No Alcohol/Drug abuse or dependency _____

Yes No Setting fires, playing with matches, fascination with fire _____

Yes No Animal cruelty _____

Yes No Carrying / using weapons _____

Yes No Runaway _____

Yes No Gang involvement / Cult participation _____

Medications (Including Reason) _____

Prior Placements _____

Special Medical Needs or Disabilities: _____

REFERRAL taken by: _____

Yes No Does referral appear to be an appropriate candidate for SCH?

If "No," summarize major concerns: _____

If "Yes," date Placement Checklist was sent: ___/___/___