

Sunnybrook Children's Home

YOUTH REFERRAL APPLICATION

Please complete all information below, as this will help us evaluate and match the youth's needs with our program.

Information about the Child

Youth's Name: _____ Sex: Male Female

Date of Birth: ____/____/____ Birth Place: _____ Race: _____

Current Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Social Security Number: ____ - ____ - _____ Religious Affiliation: _____

Is Child Receiving Any Kind of Financial Assistance (i.e. Social Security, Disability)? Y N

Does Child Have Medical Insurance? Y N Carrier Name: _____

Telephone Number () - _____ - _____ Address: _____

Policy Number: _____

Information About Placement Person or Agency

Legal Status of Person or Agency Placing the Youth: (Check Appropriate Box(es))

Managing Conservator Possessory Conservator Legal Guardian

Legal Custodian Placement Agency

Name of Person or Agency: _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Previous Placements of Child (Beginning with the most recent Placement)

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Placement Type: Psychiatric Unit Foster Home Emergency Shelter Residential Center

Other _____

Dates Resided: From: ____/____/____ To: ____/____/____

Discharge was: Successful Unsuccessful Contact Person: _____

YOUTH REFERRAL APPLICATION

Information About Parents & Step-Parents of Child

Father's Name: _____ Date of Birth: ____/____/____

Current Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Employed?: Yes No (If "No," Explain) _____

Employer Name: _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Position Held: _____ How Long: _____ Salary Per Month: \$ _____

Spouse's Name (If Remarried): _____ Date of Birth: ____/____/____

Current Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Employed?: Yes No (If "No," Explain) _____

Employer Name: _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Position Held: _____ How Long: _____ Salary Per Month: \$ _____

YOUTH REFERRAL APPLICATION

Information About Parents & Step-Parents of Child (Continued)

Mother's Name: _____ Date of Birth: ____/____/____

Current Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Employed? Yes No (If "No," Explain) _____

Employer Name: _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Position Held: _____ How Long: _____ Salary Per Month: \$ _____

Spouse's Name (If Remarried): _____ Date of Birth: ____/____/____

Current Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Employed? Yes No (If "No," Explain) _____

Employer Name: _____

Employer Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

Position Held: _____ How Long: _____ Salary Per Month: \$ _____

YOUTH REFERRAL APPLICATION

Family History of Child

- Please place a check-mark for the questions below.
- Please provide a brief explanation to all "YES" questions that are checked.

Does the Child (or a family member) have a History of:

1. Physical Abuse or Neglect? Yes No _____
2. Emotional Abuse or Neglect? Yes No _____
3. Sexual Abuse? Yes No _____
4. Poor supervision of youth? Yes No _____
5. Mental Illness? Yes No _____
6. Physical Disabilities/Injuries? Yes No _____
7. Hospitalizations? Yes No _____
8. Complications at birth? Yes No _____
9. Alcohol or Drug Abuse? Yes No _____
10. Witnessing domestic violence? Yes No _____
11. Fire Setting or playing with fire? Yes No _____
12. Sexual offending? Yes No _____
13. Gang or cult affiliation? Yes No _____
14. Cruelty to animals? Yes No _____
15. Suicides, suicide attempts/thoughts? Yes No _____
16. Physical Aggression (i.e. hits people, destroys property) Yes No _____
17. Carrying or using a weapon? Yes No _____
18. Verbal Aggression (threatens, yells, etc...)? Yes No _____
19. Injuries or medical problems? Yes No _____
20. Involvement with the police? Yes No _____
21. Being referred to Juvenile Detention? Yes No _____
22. Sexual acting out? Yes No _____
23. Running away? Yes No _____
24. Arguing, Rebelliousness? Yes No _____
25. Disrespect to authority figures? Yes No _____
26. Parents who are divorced/separated? Yes No _____
27. Parents having several boy/girl friends living in home? Yes No _____

Additional Comments: (Please write down question number & then make comment.)

YOUTH REFERRAL APPLICATION

Child's Educational History

NOTE: Please Submit All ACADEMIC & BEHAVIOR RECORDS FOR LAST (2) YEARS.

Name of Current School: _____ Grade: _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone Number: () - _____ - _____

How many years in this school district? _____

- Please place a check-mark for the questions below.
- Please provide a brief explanation to all "YES" questions that are checked.

Does the Youth Have a History of:

1. Poor grades? Yes No _____
2. Poor attendance? Skips Class? Yes No _____
3. Poor study habits? Yes No _____
4. Placement in on-campus suspension? Yes No _____
5. Being sent to the Principal's office? Yes No _____
6. Being expelled or suspended? Yes No _____
7. Disrupting class? Yes No _____
8. Not following school rules? Yes No _____
9. Not remaining on-task in class? Yes No _____
10. Failing to complete homework? Yes No _____
11. Failing to turn in homework? Yes No _____
12. Arguing with teachers or classmates? Yes No _____
13. Fighting or hitting a school official or student? Yes No _____
14. Making threats to school official or student? Yes No _____
15. Placement in Special Education Classes? Yes No _____
16. Placement in Alternative Education Programs? Yes No _____
17. Participation in extra-curricular activities? Yes No _____
18. Working below grade level? Yes No _____
19. Failing a grade? (Specify) Yes No _____

Please list any educational strengths & weaknesses of the youth below:

YOUTH REFERRAL APPLICATION

Psychological, Emotional & Social History of Child

*****NOTE: Please SUBMIT A FULL PSYCHOLOGICAL EVALUATION THAT IS COMPLETED WITHIN LAST 6 MONTHS.**

- Please place a check-mark for the questions below.
- Please provide a brief explanation to all "YES" questions that are checked

Does the Child Have a History of:

- | | | | | | |
|--|-----|--------------------------|----|--------------------------|-------|
| 1. Moodiness or frequent emotional shifts? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 2. Failing to show remorse for wrongdoing? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 3. Explosive temper outbursts? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 4. Bed-wetting and/or soiling the bed with feces? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 5. Sleeping too much or not enough? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 6. Eating too much or not enough? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 7. Depressed mood more than 2 weeks? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 8. Feelings of low self-worth? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 9. Attempting suicide or suicidal thoughts? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 10. Indecisiveness or poor concentration? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 11. Feeling "Numbed-Out" from surroundings/self? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 12. Panic Attacks? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 13. Panicking when around people/places? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 14. Being traumatized? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 15. Intrusive thoughts/flashbacks/nightmares? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 16. Amnesia? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 17. Excessive worry? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 18. Being easily distracted? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 19. Difficulty completing a task? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 20. Racing thoughts? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 21. Delusions or false beliefs not in touch with reality? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 22. Hallucinations of (visual, auditory, etc...)? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 23. Disorganized speech which interferes with communication? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 24. Increased talkativeness or interrupts conversations? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 25. Poor judgment? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 26. Frequent health complaints? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 27. Overeating and immediately vomiting? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 28. Making sudden, repetitive & involuntary movements? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 29. Sexual desire for objects (underwear, etc...)? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 30. Constantly thinking or talking about sex? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 31. Rubbing people (without their consent) for sexual gratification? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 32. Having sexual contact with others or children? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 33. Fighting, bullying or threatening others? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 34. Cruelty to animals? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 35. Destroying property? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 36. Lying or conning others? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |
| 37. Excessive arguing & complaining? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | _____ |

YOUTH REFERRAL APPLICATION

Psychological, Emotional & Social History of Child (Cont.)

Does the Child Have a History of:

- | | | | |
|--|------------------------------|-----------------------------|--|
| 38. High Risk Behavior? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 39. Repeating mistakes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 40. Oppositional-defiance & rebelliousness? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 41. Stealing or "borrowing" without permission? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 42. Trespassing, or Breaking & Entering? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 43. Criminal charges? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 44. Drug Dealing? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 45. Check or Credit Card Fraud? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 46. Drugs or alcohol usage or dependence? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 47. Playing with matches or starting fires? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 48. Negative peer associations? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 49. Attraction toward much younger or older peers? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 50. Self-Mutilation or other kinds of self-injurious behavior? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 51. Psychotropic prescriptions? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

Medical History of Child

- Please place a check-mark for the questions below.
- Please provide a brief explanation to all "YES" questions that are checked

Does the Child Have a History of, Currently Has, or Ever Received Treatment for:

- | | | | |
|--|------------------------------|-----------------------------|--|
| 1. Physical Injuries? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 2. Any Illnesses? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 3. Head Injuries? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 4. Surgeries? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 5. Convulsions? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 6. Allergies? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 7. Diabetes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 8. Tuberculoses? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 9. Emotional Disorders (i.e., Depression, ADHD, Bi-Polar, etc...)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 10. Sexually Transmitted Diseases? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| 11. Wearing Glasses or Contact Lenses? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |

Are all immunizations current? Yes No (If "NO", Please Update)

Does child currently take any prescribed medications? Yes No (If "YES" please list the medication(s) & explain what each prescription is for): _____

PHYSICAL EXAMINATION REPORT

This Report Must Be Completed by a Medical Doctor Within 60 Days Prior To a Child's Admission!

Child's Name: _____ DOB: ____/____/____

Physician's Clinical Findings

Height: ____' ____" Weight: _____ lbs. Pulse: _____/ min. Temp.: _____

Blood Pressure: _____ Head: _____

ENT: _____ Neck: _____

Chest: _____ Lungs: _____

Heart: _____ Vision: _____

Genital-Urinary: _____ Extremities: _____

Musculoskeletal: _____ Skin: _____

Neurological: _____ Abdomen: _____

Nutritional State: _____ General Appearance: _____

Family Hx of Tuberculosis, Diabetes or Other Significant Illnesses/Injuries: _____

LAB Findings

TB Mantoux: _____

Urinalysis: Sugar: _____ Albumin: _____ Microscopic: _____

Allergies: _____

Mental Health History: _____

Next Physical Exam Date: ____/____/____

Physician's Signature: _____ Date: ____/____/____

DENTIST'S EXAMINATION REPORT

This Report Must Be Completed by a Dentist Within 60 Days Prior To a Child's Admission!

DENTIST'S STATEMENT OF CLINICAL FINDINGS

I certify that I have examined _____
(Child's Name)

on the date of ____/____/____. The clinical findings are cited below:

- All findings are currently within normal limits
- Adverse clinical findings are specified on chart below:

Dentist's Signature

____/____/____
Date

Next Dental Exam Date: ____/____/____

CHILD REFERRAL APPLICATION

To help make sure the application process is not delayed, please submit the following:

- Prior to mailing the application packet, place a checkmark in the designated areas below to ensure ALL information is submitted:

1. Psychological Evaluation within the last 6 months which includes:
 - Clinical Interview
 - Mental Status Exam
 - I/Q testing (W.I.S.C. or K.B.I.T.)
 - Academic testing
 - Personality testing
 - Multi-axial diagnosis or diagnostic impression
 - Recommendations (including estimated level of care).
2. All school records including academic & disciplinary records for the last two years.
3. Juvenile probation or police records (if applicable).
4. Court order (if applicable).
5. Medical exam (within 60 days prior to placement).
6. Dental exam (within 60 days prior to placement).
7. Copy of Social Security Card.
8. Copy of Medicaid Card.
9. Shot records.
10. Birth certificate.
11. Parent's divorce decree (if applicable).
12. Prior placement records (i.e., discharge summaries, incident reports, counseling notes, etc...) if applicable.
13. Child Referral Application

I, the undersigned, affirm that the information provided in the application or other information submitted is true and accurate. I understand that submission of this application does not ensure admission. I further understand that any misrepresentations, errors or omissions of any information submitted could result in the termination of the referral process or could result in immediate termination of services provided to the youth and/or parent or agency after admission.

Signature

____/____/____
Date