Admissions Fax: 877.470.1267
admissions@springbrookbhs.com

Universal Residential Treatment Application

Incomplete applications may delay review and approval process.

Date of Application: _____ **Date Service Needed:** _____

Section I: Consumer Information

Consumer's Name: _____ Nickname: _____
Social Security Number: _____ Date of Birth:_____ Age:_____
Sex:_____ Medicaid Number**:**_____ NC LME (*if applicable*):_____
Private insurance name and ID: _____ *(Please attach a copy of card/s.)*
Consumer's Current Address:_____
Current Living Arrangement :_____
Place of Birth:_____ Race/s:_____ Primary Language: _____
Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.): Weight:_____Height:_____
_____

Section II: Guardian Information

Legal Guardian: _____
Relationship: _____ County of Legal Custody: _____
Guardian's Address: _____
Guardian's Phone Number: _____ Cell:_____
Guardian's Email: _____
Guardian ad litem name and phone (*if applicable*):
_____

Section III: Consumer Primary Referral Source Information:

Referring Agency: _____ ☐ DJJ ☐DSS ☐ DMH
County: _____ Other: _____
Community Provider Agency: _____ Phone #: _____
Agency Contact Person: _____ Phone #: _____
Referral Email: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Emergency Contact: _____ Relationship to Consumer: _____
Contact #: _____ Additional Phone #: _____

Section IV: Clinical/Diagnostic Information:

DSM V

Diagnoses:	Effective Date:	Source:

CALOCUS Score and Date: _____

ASAM (*American Society of Addiction Medicine*) Score and Date: _____

Functioning Level Scores:

IQ: _____ Verbal: _____ Performance: _____ Full Scale: _____

Examiner: _____ Date: _____

History of Abuse

If checked please provide a written description. If DSS involvement please attach documentation.

☐ Victim of Neglect: _____

☐ Victim of Physical Abuse: _____

☐ Victim of Sexual Abuse: _____

☐ Victim of Emotional Abuse: _____

☐ None

Medications	Prescribing Physician	Dosage/Frequency	Date began/compliant?

Section V: Medical Information

Allergies: _____

Special Dietary Needs: _____

Medical Conditions (past and present): *Please note most recent occurrence*

☐ **Lice**	☐ **Bulimia**	☐ **Eczema**
☐ **Anemia**	☐ **Anorexia**	☐ **Asthma**
☐ **Drug/Alcohol Abuse**	☐ **Measles**	☐ **Hay Fever**
☐ **HIV/AIDS**	☐ **Mumps**	☐ **Convulsions**
☐ **Sexually Transmitted Disease**	☐ **Chicken Pox**	☐ **Sinus Problems**
☐ **Ringworm**	☐ **Sickle Cell Anemia**	☐ **Diabetes**
☐ **Tuberculosis**	☐ **Migraine Headaches**	☐ **Hepatitis**
☐ **Chronic Urinary/Bowel Problems**	☐ **Rubella**	☐ **TBI**

Other:

_____

_____

Name and Number of Pediatrician: _____

Name and Number of Dentist: _____

Date of Last Physical Exam: _____ Last Dental Exam:_____ Last Eye Exam: _____

Dental Appliances: ☐ Yes ☐ No Contacts/Glasses: ☐ Yes ☐ No

Medical Insurance Company: ☐ Medicaid_____ ☐ NC Health Choice _____

Private Ins.(Agency): _____

Insurance Policy Number: _____

Insurance is in Whose Name? _____

(Please attach a copy of ALL insurance card/s.)

Section VI: Presenting Problems/Concerns, Reason for Referral

_____

_____

_____

_____

_____

_____

Section VII: Strengths/Abilities/Preferences

Strengths/Capabilities:

_____
_____
_____

Friendships/Social/Peer Support:

_____
_____
_____

Religion/Spirituality:

_____
_____
_____

Cultural/Ethnic Concerns:

_____
_____
_____

Meaningful Activities (community involvement, volunteer activities, leisure recreation, other interests):

_____
_____
_____

Goals for Treatment:

_____
_____
_____
_____
_____
_____

Section VIII: Previous Treatment Interventions (outpatient, inpatient, residential, group homes, etc.)

Provider/Location	Date(s)	Outcome

Section IX: Current Emotional/Behavioral Problems

_____

_____

Please describe behavior and date of the last incident.

☐ Abandonment Issues	☐ Anxiety	☐ Arson
☐ Alcohol/Drug Abuse	☐ Antisocial Behavior	☐ Stool/Feces smearing
☐ Assaultive (Physical)	☐ Assaultive (Sexual)	☐ Assaultive (Verbal)
☐ Bedwetting	☐ Eating Disorder	☐ Depression
☐ Property Destroying	☐ Fire Setter	☐ Developmental Disability
☐ Homeless	☐ Hyperactive	☐ Impulsive
☐ Lying	☐ Low Self-Esteem	☐ Loss/Grief Difficulties
☐ Physical Impairment	☐ Mental Retardation	☐ Parent Neglect Issues
☐ Perception of Reality	☐ Phobic Behavior	☐ Physical Disability
☐ Self-Destructive Behavior	☐ Sibling Related Difficulty	☐ Oppositional
☐ Social Immaturity	☐ Sexually Inappropriate Behavior	☐Stealing
☐ Suicidal	☐ Running Away	☐ Truancy
☐ Unruly/Ungovernable	☐ Cruelty to Animals	☐ Hygiene/Cleanliness Issues
☐ Problems with Sleep	☐ Gang Related Activity	☐ History w/ Weapons

Other: _____

Aggressive or Violent Behaviors

Please describe the nature of the behaviors:

☐ Verbally Aggressive, Frequency: _____

Description: _____

_____

_____

☐ Physically Aggressive, Frequency: _____

Description: _____

_____

_____

☐ Property Destruction, Frequency: _____

Description: _____

_____

_____

Has the Behavior Resulted in Injury to Others? ☐ Criminal Charges? Please describe:

_____

_____

_____

_____

Aggression is: ☐ Impulsive ☐ Planned ☐ Instrumental ☐ Triggered by Fearfulness

Where is the Client Aggressive?

_____

Known Triggers, Please Describe:

_____

_____

Main Targets of Aggression: ☐ Peers ☐ Authority Figures ☐ Family Members

(Please be specific.)

_____

_____

_____

_____

_____

Please Describe the Most Recent Episode of Aggression:

_____

_____

_____

_____

_____

_____

History of Self-Injurious/ Maladaptive Behaviors

Self-Injury

Check all that apply:
☐ Cuts on Body
☐ Conceals Cutting- Indicated Area
☐ Other Forms of Self-Injury (please describe): _____
Has Self-Injury ever Required Medical Attention? ☐ Yes ☐ No (Please explain):
_____

Suicidal Characteristics

Check all that apply:
☐ Suicidal Thoughts ☐ Past Suicide Attempts
☐ Suicidal Plans (describe): _____
Methods Used in Previous Attempts (describe): _____
Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

Homicidal Characteristics

Check all that apply:
☐ Homicidal Thoughts ☐ Past Attempts to Harm Others
☐ Homicidal Plans (describe): _____
Methods Used in Previous Attempts (please describe): _____
Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know
Does Consumer have Access to Weapons? ☐ Yes ☐ No
Please Explain: _____

History of AWOL

Runs Away from Home: ☐ Yes ☐ No
Has Run from Previous Placements: ☐ Yes ☐ No
In the Past Year how Many Times has Consumer Run? _____
Where Does He/She Go? _____
How Long is Consumer Typically AWOL? _____

Substance Abuse History

Uses	Substance	Frequency	Last Use
	Marijuana		
	Cocaine		
	Heroin/Opiates		
	Amphetamines		
	Inhalants		
	Hallucinogens		
	Alcohol		
	Other:		

Sexual Behaviors

Describe any Sexualized Behaviors Exhibited by Consumer (i.e. peeping, sexual acting out, predatory behaviors, prostitution):
_____
_____
_____

Psychotic Behaviors

Please Describe any Past/Present History of Psychosis:
_____
_____
_____
_____

Section XI: Family Information

Mother's Name: _____

Address: _____

Telephone Number: Home: _____Work:_____Cell:_____

Ethnicity: _____ Education Level: _____ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

Father's Name: _____ Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Ethnicity: _____ Education Level: _____ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

Check all that apply:

Are Parents: ☐ Married ☐Separated ☐ Divorced ☐Never Married ☐Deceased Mother ☐Deceased Father

Have Parental Rights Been Terminated: ☐Yes ☐No If so, Who and When?

_____

Siblings:

Name	Age	Gender

Are Siblings in Out-of-Home Placements? ☐ Yes ☐ No

If yes, please specify: ☐ DSS Foster Care ☐ Relatives ☐ Incarcerated ☐ Group Home ☐ Other:

Explain: _____

Section XII: Family Social History

Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked, then please explain.

☐ Criminal Activity
☐ Child Abuse
☐ Inappropriate Sexual Behavior
☐ Treatment Disruption
☐ Psychiatric Illness
☐ Substance Abuse
☐ Suicide
☐ Other:

_____

_____

_____

_____

_____

_____

(If other pertinent family history, then please document separately and attach.)

Section XIII: Authorized Contacts/Resources for continuity of care

Please include individuals you wish to be included in therapeutic process

Name	Relationship	Address	Telephone Number	Types of Contact (visitation, telephonic, written, etc.)

Special Conditions/Restrictions for Home Visits?_____

_____

Section XIV: School Information

Last School Enrolled: _____ District: _____

Previous Enrollments: _____

Grade: _____ Special Classes: ☐ED ☐LD ☐Resource ☐BEH ☐Homebound

☐Other: _____

Any History of Truancy? ☐ Yes ☐ No Grade(s) Repeated: _____

Current IEP? ☐ Yes ☐ No

Suspensions/Expulsions: _____

Section XV: Agency/Provider Involvement

Indicate all agencies currently involved:

☐ DSS ☐ Dept. of Mental Health ☐ DJJ ☐ DDSN ☐ Vocational Rehabilitation

☐ Other: _____

Case Manager(s) Contact Information *(if applicable)*: _____

_____

_____

Section XVI: Court History

Does Consumer Have a Criminal Record? ☐ Yes ☐ No

Offenses	Conviction Dates	Tried as Juvenile or Adult

Pending Charges: _____

Is Consumer on Probation? ☐ Yes ☐ No Name and Contact: _____

Has Placement been recommended by Court? ☐ Yes ☐ No *(If yes, please attach court order.)*

Additional information:_____

_____

_____

_____

Section XVII: Final Comments

Estimated Length of Stay: ☐ 90 Days ☐ 180 Days ☐ 270 Days ☐ 360 Days

Anticipated Discharge Plan: ☐ Return Home ☐ Step Down Placement ☐ Community Supports

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signatures (*please sign as applicable*):

Legal Guardian	Print Name	Date
Referring Agency	Print Name	Date
Other Team Member	Print Name	Date
Care Coordinator	Print Name	Date