NORTH SPRING BEHAVIORAL HEALTHCARE APPLICATION FOR ADMISSION			
Date Completed			
Applicant Name			
Sex (circle)	Male Female Transgender	**Birth Date**	
Referral Source			
Agency Name			
Referral Phone #			
Referral Email			
Types of Insurance			

Why are you exploring residential treatment for this young person?

Family Dynamics	
Name of Parents/Custodians	
Family Phone Numbers	
Family Email Addresses	
Describe history of family noncompliance/disruption of treatment	
Is family available for family therapy?	□ Yes □ No

Education												
Current Grade Level	2	3	4	5	6	7	8	9	10	11	12	College
School District												
IEP Designation	504		ED		OHI		LD		ASD		ID	Other_____
Most Recent FSIQ												

Placement/Intervention History		
What setting is the referral currently residing?	□ Home □ Detention □ Residential Treatment_____ □ Group Home _____	□ Inpatient Acute _____ □ Therapeutic Foster Home □ Shelter

List placement/intervention history starting with most recent and working backwards			
Placement/Intervention	**Level of Care**	**Date Started-Date Ended**	**Successful?**
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
Describe why any placement was marked as unsuccessful			

Has this referral ever been discharged from a Residential Treatment Center due to dangerous behaviors or treatment noncompliance?	□ Yes □ No
If yes to the question above please describe where and the circumstances around the discharge	

Medical/Psychiatric

List current Psychiatric Diagnosis	
List Current Medical Conditions/Diagnosis	

Are there restrictions on the referrals level of physical activity?	□ Yes □ No
If yes to the question above please describe restrictions and how they are currently managed	

Current Medications

Medication	Dosage

Allergies

Allergen	Reaction

Substance Abuse □ No known substance abuse history

Alcohol: □ Yes □ No	Speed/Amphetamine: □ Yes □ No	Phencyclidine: □ Yes □ No
Marijuana: □ Yes □ No	Club Drugs: □ Yes □ No	Hallucinogens □ Yes □ No
Cocaine: □ Yes □ No	Opioids: □ Yes □ No	Inhalants □ Yes □ No
Other: _____	LSD: □ Yes □ No	Sedative/Hypnotics □ Yes □ No

Initial Discharge Plan

How many ***months*** are you expecting this referral to require this level of care?	1 2 3 4 5 6 7 8 9 10 11 12+
Where is the likely discharge residence for this referral?	
Describe barriers to discharge planning outside the presentation of the patient	

Please list any special requests or considerations the admissions team needs to be aware of in considering this referral

Presenting Behaviors			
Aggression ☐ No physical aggression			
The referral's aggression takes the form of	☐ Hitting ☐ Kicking ☐ Unprovoked Violence ☐ Biting ☐ Spitting ☐ Inciting group violence	☐ Violence towards adults ☐ Violence towards peers ☐ Threats ☐ Instigation/Bullying ☐ Homicidal ☐ Posturing	☐ Weapon Making/Using ☐ Premeditated Violence ☐ Fire Setting ☐ Animal Cruelty ☐ Throwing items ☐ Rage
At its worse the referral's aggression has looked like			
How often does referral present with physically aggressive behaviors?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly		
Has aggression required physical restraint?	☐ Yes ☐ No		
If yes when was the last physical restraint?			
If yes how often is physical restraint required to maintain safety?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly		
Has anyone ever been injured due to physical violence?	☐ Yes ☐ No		
Has 1 to 1 supervision been required to manage aggression?	☐ Yes ☐ No		
Has PRN medication or medical restraint been required to manage aggression?	☐ Yes ☐ No		
Has hospitalization from an RTC or JDC been required to manage aggression?	☐ Yes ☐ No		
Suicidality/Self-Harm ☐ No self-harm/suicidality			
The referrals self-harm or suicidality takes the form of	☐ Suicidal Ideation ☐ Suicide Planning ☐ Suicide Attempts ☐ Overdose ☐ Burning ☐ Sharps seeking	☐ Cutting ☐ Skin Picking ☐ Hair pulling ☐ Ingestion of inedible items ☐ Med cheeking ☐ Hitting self	☐ Binging ☐ Purging ☐ Restricting ☐ Threats to harm self ☐ Threats to kill self ☐ Strangulation
At its worse the referral's self-harm or suicidality has looked like			
How often does referral engage in self-harm or suicidal behaviors?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly		
Has this behavior required physical restraint?	☐ Yes ☐ No		
If yes when was the last physical restraint?			
If yes how often is physical restraint required to maintain safety?	☐ Multiple a day ☐ Daily ☐ Weekly ☐ Monthly		
Has the referral ever been seriously injured due to self-harm/suicidality?	☐ Yes ☐ No		
Has 1 to 1 supervision been required to manage self-harm/suicidality?	☐ Yes ☐ No		
Has PRN meds or medical restraint been required to manage this behavior?	☐ Yes ☐ No		
Has hospitalization from RTC or JDC been required to manage this behavior?	☐ Yes ☐ No		
Sexual Aggression ☐ No sexual aggression			
The referrals sexual acting out takes the form of	☐ Sexual comments ☐ Sexual gestures ☐ Public masturbation ☐ Grooming younger/weaker peers ☐ Sexual Note Passing ☐ Brushing up on others intentionally ☐ Sexual assault by threat of violence ☐ Paying for sexual acts	☐ Sexual threats ☐ Rape ☐ Sodimization ☐ Digital penetration/oral sex ☐ Sexual aggression towards adults ☐ Sexual aggression to younger peers ☐ Excessive masturbation ☐ Use of phone sex lines	☐ Sexual aggression to family ☐ Sexual aggression to peers ☐ Sexual aggression to strangers ☐ Sexual violence fantasies ☐ Excessive pornography use ☐ Pornography use on public computers ☐ Sexually aggressive pornography use ☐ Stalking
At its worse the referral's sexual aggression has looked like			
How often does referral engage in sexually aggressive behaviors?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly		
Has this referral ever had a psychosexual risk assessment?	☐ Yes ☐ No		
If yes what was the level of risk indicated in the psychosexual	☐ Mild ☐ Moderate ☐ High		
If yes what setting does the psychosexual indicate that level of risk is in	☐ If staying in the community ☐ If in a secure treatment setting		
Has referral engaged in sexual aggression in a RTC, JDC or Inpatient setting?	☐ Yes ☐ No		
Does referral require a single room due to risk of sexual acting out?	☐ Yes ☐ No		
Is referral permitted to be around younger peers	☐ Yes ☐ No		

Other High Risk Behaviors ☐ No Psychosis ☐ No Sexual Reactivity/Risk Taking ☐ No AWOL/OOA			
The referrals behaviors takes the form of	Psychosis ☐ Audio Hallucinations ☐ Visual Hallucinations ☐ Command Hallucinations ☐ Delusional Thinking ☐ Flashbacks/Nightmares ☐ Dissociation ☐ Paranoia ☐ Disorganized thinking	Sexual Reactivity/Risk Taking ☐ Boundary Issues ☐ Sexual Comments or Gestures ☐ Sexual Preoccupation ☐ Multiple sexual partners ☐ Having sex with older partners ☐ Sex while AWOL or Intoxicated ☐ Sexting/Use of Social Media for Sex ☐ Sexual Trafficking	AWOL/Out of Area ☐ Leaves home without permission ☐ Leaves school without permission ☐ AWOL from previous placements ☐ AWOL plotting with peers ☐ AWOL with intent of substance abuse ☐ AWOL with intent of sexual behaviors ☐ AWOL as an escape when dysregulated ☐ Premeditated AWOL or OOA
At its worse the referral's behaviors have looked like			

How often does referral engage in AWOL or Out of Area	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly
How long do AWOL or Out of Area Incidents last for?	☐ Less than 1hr ☐ 1hr-6hrs ☐ 6hrs-24hrs ☐ More than 24hrs
What setting does sexual risk taking/reactivity present in?	☐ Community ☐ School ☐ Inpatient/JDC/RTC
How often does referral engage in sexual risk taking/reactivity?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly
What gender is sexual risk taking/reactivity geared towards	☐ Males ☐ Females ☐ Both Genders
What frequency does referral present with psychotic symptoms?	☐ Multiple times a day ☐ Daily ☐ Weekly ☐ Monthly
How incapacitating are psychotic symptoms for the patient when present?	☐ Unable to complete ADL's ☐ Able to complete ADL's with assistance ☐ Not incapacitating to ADL's

Other Concerns (Circle All That Apply)

Property Destruction	Unmotivated for Treatment	Manipulating	Social Isolation	Poor Hygiene
Lying	Stealing	Tantrums	Truancy	Poor Social Skills
Reactive Attachments	Oppositional	Deceitfulness	Bulling Others	Social Isolation
Gang Involvement	Disruptive	Attention Seeking	Bullied by Others	Other_____
Depression	Anxiety	Attention Seeking	Avoidant	Fearful
Inattention	Hyperactive	Explosive Reactions	Mood Swings	Self-Sabotage
Mania	Obsessive Compulsive	Somatic Symptoms	Frustrates Easily	
Poor Self Esteem	Weight Loss	Weight Gain	Sleep Issues	

Legal						☐ No Legal Charges
Charge		**Date**		**Conviction**	**Yes**	**No**
Charge		**Date**		**Conviction**	**Yes**	**No**
Charge		**Date**		**Conviction**	**Yes**	**No**
Charge		**Date**		**Conviction**	**Yes**	**No**
Charge		**Date**		**Conviction**	**Yes**	**No**
Describe the charges not already described in this application						

Trauma	
Has this young person ever been physically abused?	☐ Yes ☐ No
If so please describe	
Has this young person ever been The victim of neglect?	☐ Yes ☐ No
If so please describe	
Has this young person ever been sexually abused?	☐ Yes ☐ No
If so please describe	
Are there other traumas that we should be aware of?	☐ Yes ☐ No
If so please describe	
Has all abuse neglect been reported to CPS?	☐ Yes ☐ No
Has DSS/CPS ever been involved with this referral and the family?	☐ Yes ☐ No
If so please describe	
Is DSS/CPS Currently involved with the family?	☐ Yes ☐ No
If so please describe	

Attach this application to, educational, behavioral and medical records sent for review. Send to Brooke.peters@uhsinc.com , Olivia.corbin@uhsinc.com or fax to 703-777-1038