Purchase Youth Village

Referral Information for Placement

Date: ____________________

Name of Child: ____ **Sex: Male or Female**

Date of Birth: ___________________ **Age:** ________**Social Security Number:** ________________

Mother's Name: ____

Home phone number: _________________________ **Cell:**_____________________________

Address:_____________________________________**City/ST:**__________________**Zip:**_________

Employed as: _______________________________________ **Work Number:**____________

Employer address: ____

Email address ____

Father's Name: ____

Home phone number: _________________________ **Cell:**_____________________________

Address:_____________________________________**City/ST:**__________________**Zip:**_________

Employed as: _______________________________________ **Work Number:**____________

Employer address: ____

Email address ____

Step-Parent's Name: ____

Home phone number: _________________________ **Cell:**_____________________________

Address:_____________________________________**City/ST:**__________________**Zip:**_________

Employed as: _______________________________________ **Work Number:**____________

Employer address: ____

Email address ____

Reason for Referral: ____

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Chief Complaint:

______Very unhappy	______Impulsive	______Fire-Setting
______Irritable	______Stubborn	______Stealing

_______Temper Outburst _______Lying _______Disobedient
_______Withdrawn _______Infantile _______Daydreaming
_______Fearful _______Aggressive _______Overactive
_______Destructive _______Rocking _______Shy
_______Mean to others _______Truancy _______Sickly
_______Short attention span _______Self-mutilating _______Soiled pants
_______Bed-wetting _______Sexually acting out _______Eating problems
_______Sleeping problems _______Head banging _______Distractible
_______Lacks initiative _______Undependable _______Peer Conflict
_______Strange behavior _______Strange thoughts _______School Performance
_______Tobacco Use _______Alcohol Use _______Phobic
_______Dependency on illegal, prescribed, or over the counter drugs

Explain:____
____
____
____
____
____

How long have these problems occurred? (number of weeks, months years)________________
____
____
____
____
____

Problems perceived to be: ___very serious ___serious ___not serious

Current Psychiatric Diagnosis (if known): _____________________________________
____
____
____

Current Psycho/social stressors: ____
____
____
____

Name of Place and Date of most recent psychological evaluation:

____

Name of Place Date of most recent psychiatric evaluation:

____

Is the child currently involved in mental health treatment/program? ___YES ___NO
(if yes, please explain):____

____
____
____

Is there any history in the child's family of:

_______Mental illness _______schizophrenia _______epilepsy
_______birth defects _______drug use/abuse _______alcohol use/abuse

(if yes, please explain)____

____
____
____
____
____

Family Dynamics:

Who does the child live with?

___Mother/Father ___Mother/Step-Father ___Father/Step-Mother

___Other, please explain: ____

____
____
____

Who has custody of the child if parents are divorced? ______________________

____
____
____

Does the child have siblings? ___YES ___NO
(if yes, please explain):____

____
____
____
____

Does the child get along with step parents? ___YES ___NO
(if no, please explain):____

____
____
____
____

Is the child adopted? ___YES ___NO
(if yes, please explain):____

____

Note all health problems that child has HAD or HAS NOW:

	AGE		AGE
___High Fevers	_____	___Dental problems	_____
___Pneumonia	_____	___Weight Problems	_____
___Flu	_____	___Allergies	_____
___Encephalitis	_____	___Skin problems	_____
___Meningitis	_____	___Asthma	_____
___Convulsions	_____	___Headaches	_____
___Unconsciousness	_____	___Stomach problems	_____
___Concussions	_____	___Accident-prone	_____
___Head Injury	_____	___Anemia	_____
___Fainting	_____	___Dizziness	_____
___Tonsils out	_____	___Sinus problems	_____
___Heart problems	_____	___Vision problems	_____
___Hyperactivity	_____	___Hearing problems	_____
___Earaches	_____	___High or low blood pressure	_____

___Other illness (explain): ____

____

____

____

Does your child have any current medical issues? ___**YES** ___**NO**
(if yes, please explain):____

____

____

____

____

Please list any illness/medical condition requiring immediate attention: ___________________

____

____

____

List of current medications:

Medication	Dosage	Times per day

In the last year, has any medication changed from list above, if so please list which medication and why: ____________________

____

Please list any medication, food, etc. the child is allergic to: ____________________

Is the child pregnant or parenting? ___YES ___NO Please explain:____________________

Has the child ever been hospitalized in a psychiatric/acute care hospitalized? ___YES ___NO (if yes, please explain and list dates)

____

Does the child have any abuse history: (please check all that apply)

Neglect: ___No ___YES ___Suspected Abandonment: ___No ___YES ___Suspected
Emotional: ___No ___YES ___Suspected Physical: ___No ___YES ___Suspected
Sexual: ___No ___YES ___Suspected
If yes or suspected, please give more detail information: ____________________

____

LEGAL History:

Has your child ever had difficulty with the police? ___YES___NO
(if yes, please explain):____________________

Has your child ever appeared in juvenile court? ___YES ___NO
(if yes, please explain):____________________

Behavioral Current /History:

Does your child currently present a danger to themselves or have suicidal behaviors?
___YES ___NO
(if yes, please explain):____________________

Is your child currently a danger to others and/or physical and/ verbal aggressive behaviors?
___YES___NO
(if yes, please explain):____

Does your child have a current/history of Fire Setting? ___YES ___NO
(if yes, please explain):____

Does your child have a history or is currently an AWOL/Runaway risk? ___YES ___NO
(if yes, please explain):____

Does your child have a history or is currently sexual acting out or a sexual perpetrator?
___YES ___NO
(if yes, please explain):____

EDUCATION:

Name of current school: ____Grade: ____________

Child's IQ ________

Does your child have any specific learning difficulties? ___YES ___NO
(if yes, please explain):____

Does your child attend school on a regular basis? ___YES ___NO
(if no, please explain):____

Has your child been suspended or expelled from school? **___YES** **___NO**
(if yes, please explain):____
____
____
____

Does your child have an IEP? **___YES** **___NO**
(if yes, please give dates and explain):____
____
____
____
____

Please attached any of the following if available:

Recent Psychological/Psychiatric (if available)

Recent Physical (if available)

Recent IEP (if available)

Recent Treatment Plans

Recent Assessments

Copy of custody papers

Most recent TB skin test

Insurance Information:

Insurance Provider: ___________________________________

Insurance number: ____________________________________

Need Copy of Insurance card

Signature of person filling out all above information: ______________________________

Date: __________________

Child Checklist of Concerns and Positive Traits

Child's Name:____ **Date:**______________

This checklist contain concern, as well as positive traits, that apply mostly to children; therefore, mark any items that describe your child. Feel Free to add any others at the end under "Any other characteristics".

___Affectionate
___Argues, "talks back", smart-alecky, defiant
___Cheats
___Bullies/intimidates
___Teases/Provokes
___Inflicts pain on others
___Bossy to others
___Cruel to animals
___Concern for others
___Cries easily, feelings hurt easily
___Waste time, dawdles, procrastinates
___Uncooperative
___Difficulties with parent's paramour/new marriage/new family
___Dependent immature
___Doesn't follow rules
___Developmental delays
___Wants to drop out of school
___Disrupts family activities
___Drug use
___Disobedient
___Alcohol use
___Insulting
___Negativism
___Inattentive
___Appetite increase
___Appetite decrease
___Does not like to exercise,
___Lets extracurricular activities interfere with academics
___Failure in school
___Fearful
___Violent, aggressive, fighting
___Fire setting
___Friendly, outgoing
___Hypochondria, always complains of feeling sick
___Immature, has only younger playmate
___Clowns arounds
___Imaginary playmates
___Independent
___Interrupts
___Yells
___Lack of organization
___Lacks respect for authority
___Learning disability
___Likes to be alone
___Lying
___Legal issues
___Low frustration tolerance
___Moody

___Mute, refuses to speak

___Developmental disability

___Nail biting

___Nervous

___Nightmares

___Obedient

___Needs to be supervised at all times

___Overactive

___Oppositional

___Pouts

___Recent move, new school, loss of friends

___Prejudiced

___Hyperactive

___Unhappy

___Runs Away

___Shy

___Sexual preoccupation

___Public masturbation

___Inappropriate sexual behaviors

___Bad relationships with siblings

___Speech Difficulties

___Stubborn

___Suicide talk

___Suicide attempt

___Speech Difficulties

___Responsible

___Rocking or other repetitive movements

___Swearing

___Temper tantrums

___Thumb sucking, finger sucking

___Hair Chewing

___Bullied

___Truant from school

___Under active, lethargic

___Uncoordinated, accident-prone

___Wetting/soiling bed or clothes

___Tics – involuntary rapid movements, noises, or word productions