



**Three Rivers Treatment Center
Application for Admission**

Thank you for choosing Three Rivers Treatment Center as an option to treat your youth. In an effort to ensure that we provide the most appropriate and fulfilling treatment experience, we do ask for quite a bit of information for our clinical team to review. While we understand that this may be time consuming, it is important for us to know if we are able to meet the needs of the youth that you are referring.

We appreciate your understanding and commitment to this youth and his or her success. Should you have any questions please feel free to contact:

Cindy Hale, MA
434-676-1378 extension 110
cindy@3rtc.com

Below is a complete checklist:

Physical & Medical History

- Immunization record including TB results within past year
- History & Physical
- Information regarding past serious illnesses, injuries or infectious diseases

Social & Developmental Summary

- Social history describing family structure and relationships – remember family does not have to be blood related. Family can include any supportive and healthy person in a youth’s life
- Current DSM-V diagnosis
- Previous treatment history to include: dates of outpatient therapy, dates of outpatient medication management, dates of inpatient hospitalization, psychological/psychiatric evaluations, treatment plans, discharge summary, progress reports, etc.
- Results of any psychological, psychiatric, or neurological evaluations

Education

- Educational evaluation and test scores
- Current Individual Education Program (IEP) or 504 Plan
- All paper work related to ISAEP if enrolled

Funding

- Current CANS
- CON, dated within 30 days
- Copy of insurance card, copy of dental and eye insurance information
- FAPT service plan



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Date: _____

Dear Mr./Mrs.: _____

Please find enclosed the admission paperwork pertaining to, _____ admission into our program. Although you provided verbal consent to treat your child in the program, our admissions process also requires written signatures on the enclosed papers.

Please sign each form where indicated and return the forms to us in the enclosed self-addressed envelope or when you visit for family therapy and/or visitation.

If you have any questions, please do not hesitate to contact us at **434-676-1378**. Thank you for your help and understanding.

Sincerely,

Christi DeFrancesco, LCSW & Jennifer Bennett MA
Your Admissions Team



Three Rivers Treatment Center

Application for Admission

Name and relationship of person(s) referring this youth: _____

parent legal guardian adoptive parent foster parent probation officer other: _____

Identifying Information of Youth

Youth's full name: _____ SSN: _____

Preferred gender: _____ Biological Sex: _____ DOB: _____ Age: _____

Hair Color: _____ Eye color: _____ Height: _____ Weight: _____

Race: _____ Cultural Identification: _____ Religious Preference: _____

Guardian Information

Name: _____ relationship: _____

Address: _____

Phone: _____ Alternative phone: _____

Email: _____

Placement Information

Youth's current placement: home hospital other out of home placement: _____

If this youth has been placed out of his or her home, for how long? _____

Child's address if different than the legal guardian: _____

Need for immediate placement: _____

What is the primary concern for this youth: _____

How has the youth's behaviors impacted those around him/her? _____

Concerning behavior checklist: If yes, please as when, where, and frequency of symptom or behavior

YES NO Fire setting _____

YES NO Property destruction _____

YES NO Depression _____

YES NO Self-Harm _____

YES NO Substance Use _____

YES NO Aggression _____

YES NO Running away _____

YES NO Dropping grades _____

YES NO Social withdrawal _____

YES NO School trouble _____

YES NO Change in peer group _____

YES NO Peer conflict _____

YES NO Change in sexual patterns _____

YES NO Inappropriate sexual behavior _____



Prior Treatment Attempts

Type of Service: therapy, in-home, hospital, medication management	Date	Place	Outcome: some change, no change, etc.

Please explain how prior treatment attempts were not successful: _____

Professional Evaluations Complete

Type of Exam	Date (mm/yy)	Place/Provider	Recommendations
Psychological evaluation			
Psychiatric evaluation			
Neurological evaluation			
Forensic psychological eval			

Current Medications

Medication	Dosage	Frequency	Start Date

Medication allergies: _____

Medications that cause adverse reactions: _____

Ineffective medications: _____



Medical Screening

Please indicate if this youth has any of the following medical concerns. If yes, please provide details.

- YES NO Asthma: _____
- YES NO Diabetes: _____
- YES NO Seizures: _____
- YES NO Cardiac Issues: _____
- YES NO Allergies: _____
- YES NO Head injury: _____
- YES NO Visual Impairment: _____
- YES NO Hearing Impairment: _____
- YES NO Physical limitations: _____
- YES NO STI: _____
- YES NO Infectious disease: _____

Education

Where does the youth currently attend school? _____

If the youth is not enrolled, please explain: _____

Current grade level: _____ IEP YES NO, category: _____ Date of IEP: _____

504 Plan YES NO

Mental Health

If known, Full Scale IQ: _____ Verbal IQ: _____ Performance IQ: _____

Current DSM V Diagnosis: _____

Testing that you believe this youth may need: _____

Please list top 3 emotional & psychological needs for this youth from your perspective:

1. _____
2. _____
3. _____

Preliminary Behavior Support Planning

Please list 3 behavioral/character strengths of this youth:

1. _____
2. _____
3. _____

Please list 3 behavioral/character limits of this youth:

1. _____
2. _____
3. _____



Please list top three triggers for unsafe behaviors:

1. _____
2. _____
3. _____

Please list top three interventions that help in times of emotionally overwhelming situations or crises:

1. _____
2. _____
3. _____

What techniques have you seen the youth use to help manage overwhelming emotions successfully:

1. _____
2. _____
3. _____

Legal

YES NO Any past or current legal issues?

If yes, please describe: _____

YES NO Currently on probation? If yes, list charges: _____

If yes, name and locality of Probation Officer: _____

Community Contacts

Our partnership with community support systems is vital for the success of our youth and our program. Please list any and all community agencies (DSS, CSA, FAPT, CASA, Court Services Unit/Probation Officer, Victim Advocate, etc.) that are involved with this youth so that we may keep them informed.

Name		Agency	
Phone		Alternative Phone	
Fax		Email	

Name		Agency	
Phone		Alternative Phone	
Fax		Email	

Name		Agency	
Phone		Alternative Phone	
Fax		Email	

Name		Agency	
Phone		Alternative Phone	
Fax		Email	

Name		Agency	
Phone		Alternative Phone	
Fax		Email	

Signature: _____ Date: _____