Thank you for choosing Three Rivers Treatment Center as an option to treat your youth. 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:

Karima ElMadany
434-676-1378 extension 110
karima@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 evaluations/SOL scores/Testing
☐ Current Individual Education Program (IEP) or 504 Plan
☐ All paperwork related to ISAEP if enrolled
☐ Attendance & Transcripts/report cards
☐ Discipline records
☐ Achievement records

Funding

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

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: ________________________