NORTH SPRING BEHAVIORAL HEALTHCARE

Application and Checklist

The following admissions checklist is to be used as a guide when sending referral information to North Spring Behavioral Healthcare, Inc. Each packet received is reviewed by our Admissions Committee to determine appropriateness for the program. It is essential that we receive documentation that is current and presents an overall picture of the potential resident. This information is needed prior to the admission of a resident.

We appreciate your support and look forward to working with you. Should you have any questions, please do not hesitate to call Admissions at 703-777-0800 or 800-777-8855.

Please make sure that your packet contains as much of the following information as possible:

SOCIAL and PSYCHIATRIC SUMMARY

a) Social History*
b) Psychological and/or Psychiatric Evaluations (Current DSM-IV diagnosis (Axis I – V))*
c) Previous treatment/placement history (staffing reports, discharge summary, treatment plans, progress reports, etc.)*
d) Current behavioral functioning: strengths, talents and problems
e) Custody Status

PHYSICAL EXAMINATION

a) Immunization record
b) TB Test
c) Last Dates of Dental, Vision, or Gynecological Visits
d) Health Physical
e) General physical condition; nutritional requirements; or allergies.

EDUCATION

a) Current Grade and Report Card, school transcripts
b) Student’s eligibility for Special Education placement*
c) Educational evaluation and test scores, if any
d) Individualized Education Program (IEP), if identified as special education*

*These items are deemed essential. A packet will not be reviewed until this documentation is received by Admissions.
NORTH SPRING BEHAVIORAL HEALTHCARE
APPLICATION FOR ADMISSION

Part I – to be completed by referral source

Resident’s Name:

__________________________________________
Last           First           Middle

Resident’s Address: __________________________________________

Street

City          State          Zip Code          Home Phone

Sex:_____ Age:______ Birthdate:__________________ Birthplace:__________________

Race: ________ Religious Preference: ___________________________________________

Resident’s Social Security Number: ___________________________________________

Resident being admitted from: Home_____ Hospital _____ Other: ______________________

If other than home, give name, address, telephone number of facility:

________________________________________________________________________________

Name and address of legal guardian, if not parent:

Phone Number: __________________________________________

Reimbursement Source(s):   ( ) VA Medicaid    ( ) IV-E    ( ) State Agency
                        ( ) DC Medicaid    ( ) CSA    ( ) MD Medicaid
                        ( ) WV Medicaid    ( ) Tricare

( ) Private Insurance   ( ) Parents   ( ) School System   ( ) Other ________________

Specific insurance information (company/agency name, ID#, claims address, etc. Include a copy of the card):

________________________________________________________________________________

Referral Source Name: ____________________________ Locality: ______________________

Phone/Email: __________________________________________

CSA Coordinator: ________________________________ Phone/Email: ____________________

How did you learn about North Spring Behavioral Healthcare, Inc.?

________________________________________________________________________________
PART II – Social - Developmental Summary (completed by referral source)

Resident’s Name: ____________________________________________________________

Father’s Name: ___________________________________ Occupation: ________________

Father’s Home Address: ____________________________ Home Phone: ________________

Father’s Employer: ____________________________ Business Phone: __________________

Father’s Social Security Number: ____________________________ Date of Birth: __________

Mother’s Name with Maiden Name: ____________________________ Occupation: ________________

Mother’s Home Address: ____________________________ Home Phone: ________________

Mother’s Employer: ____________________________ Business Phone: __________________

Mother’s Social Security Number: ____________________________ Date of Birth: __________

Marital Status: ____________________________

Brothers/Sisters: __________________________________ Age: __________

________________________________________ Age: __________

________________________________________ Age: __________

Brief description of family relationships:

________________________________________

________________________________________

________________________________________

Current behavioral functioning (strengths, talents and problems):

________________________________________

________________________________________

________________________________________

Documentation of need for care apart from the family setting:

________________________________________

________________________________________

________________________________________

Legal involvement:

________________________________________

Protection needs specific to this applicant: ____________________________
**Axis Diagnosis (If known)**

I. ___________________________            ___________________________
   ___________________________            ___________________________
   ___________________________            ___________________________

II. ___________________________            ___________________________

III. ___________________________            ___________________________

IV. ___________________________________________________________________
   ___________________________________________________________________

V. ___

**Expectations / Treatment Goal Ideas for Resident while at North Spring:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Referrals for the Sexually Acting Out or Sexually Reactive Program**

Is reunification therapy desired with the resident’s family?  ____ Yes  ____ No

*Reunification therapy can only be conducted at North Spring if the victim is receiving therapeutic services and both the victim and their therapist are willing to be involved in reunification therapy with the resident and their North Spring therapist.*

If yes, Victim Initials and Relationship with resident:

________________________________________________________________________

Victim’s Therapist and Contact Information:

________________________________________________________________________
**Alternative placements/services tried in the past, please list most current first.**

(i.e. outpatient, in-home, mentoring, residential, etc) | Dates | Successful
---|---|---
1. |  | Y N
2. |  | Y N
3. |  | Y N
4. |  | Y N
5. |  | Y N
6. |  | Y N
7. |  | Y N

If not successful, please explain reasons for failure?

1. ___________________________________________________________________________________________
2. ___________________________________________________________________________________________
3. ___________________________________________________________________________________________
4. ___________________________________________________________________________________________
5. ___________________________________________________________________________________________
6. ___________________________________________________________________________________________
7. ___________________________________________________________________________________________

School Attending:______________________________________________________________

School Address:____________________________________________________________________

Telephone Number:_________________________Contact Person:________________________

IEP Developed By (send current copy):______________________________IEP Date:____________

Educational label:   ED_____ LD _____ OHI______ Grade Placement:____________________

Current Class Schedule:________________________________________________________

____________________________________________________________________________________

Educational needs specific to this applicant:____________________________________________

____________________________________________________________________________________

Full Scale IQ Score _____ Test Administered: _________________ Date of Testing: __________
MEDICAL HISTORY OF APPLICANT

1. Height/Weight: _____ Feet _____ Inches _____ lbs

2. Describe any serious illnesses or chronic conditions of applicant’s parents and siblings, if known: Check if applicable ( ) NONE ( )UNKNOWN ________________

3. Please describe the following about the applicant:
   a. Past serious illnesses or infectious diseases (name of disease, duration, etc):
      ______________________________________________________________________
   b. Serious injuries: ______________________________________________________________________
   c. Impact of any of these on current health: ______________________________________________________________________
   d. Physical Handicaps: ______________________________________________________________________
   e. Visual disorder: ______________________________________________________________________
   f. Hearing problems: ______________________________________________________________________
   g. Suffers from Enuresis (frequent urinary accidents during the day or at nighttime – please describe):
      ______________________________________________________________________
   h. Suffers from Encopresis (inability to control elimination of stool/intentional or unintentional soiling of pants – please describe):
      ______________________________________________________________________
   i. Child is not able to perform the following activities of daily living: ______________
      ______________________________________________________________________

4. Medications used currently:
   ______________________________________________________________________
   ______________________________________________________________________

5. Past medications used:
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

6. Is applicant allergic to any medications or foods? Yes ☐ No ☐ If yes, name medication and describe symptoms. ______________________________________________________________________

7. Does applicant have history of substance abuse? Yes ☐ No ☐ If yes, please give name of drug, and any facts surrounding use e.g., length of use, treatment etc.
   ______________________________________________________________________
   ______________________________________________________________________
