CAROLINA DUNES
BEHAVIORAL HEALTH

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ADMISSION APPLICATION

PERSON/AGENCY MAKING APPLICATION CASE #: _____

AGENCY MAKING REFERRAL: _____

PERSON MAKING REFERRAL: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

EMAIL: _____

PHONE: _____ FAX: _____

POTENTIAL CLIENT

CLIENT NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

COUNTY: _____ PHONE: _____

LME/MCO: _____ LME/MCO #: _____

LME/MCO CONTACT PERSON: _____

DOB: _____ AGE: _____ GENDER: _____ RACE: _____

HEIGHT: _____ WEIGHT: _____ SSN: _____

FINANCIAL INFORMATION (ATTACH COPY OF INSURANCE CARD)

MEDICAID #: _____ HEALTH CHOICE #: _____

OTHER INSURANCE CO. NAME: _____

INSURANCE CO. ADDRESS: _____

INSURANCE CO. PHONE #: _____

INSURED (MEMBER) NAME: _____

GROUP #: _____ PLAN #: _____

SUBSCRIBER #: _____ SSN: _____

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CURRENT PLACEMENT

☐ HOME ☐ LEVEL 3 ☐ LEVEL 4 ☐ DETENTION ☐ ACUTE ☐ TFC ☐ OTHER

AGENCY NAME: _____

POINT OF CONTACT: _____

EMAIL: _____

PHONE: _____ FAX: _____

LENGTH OF STAY: _____ DISCHARGE DATE: _____

REASON FOR NEED FOR NEW PLACEMENT: _____

_____

NUMBER AND TYPES OF RESTRICTIVE INTERVENTIONS IN LAST 30 DAYS: _____

_____

CUSTODY ☐ PARENTS ☐ DSS ☐ OTHER: _____

MOTHER'S NAME: _____

ADDRESS: _____

EMAIL: _____

PHONE: _____ MARITAL STATUS: _____

SPOUSE NAME: _____

DIVORCED/UNMARRIED, WHAT IS CUSTODY ARRANGEMENT: (PROVIDE DOCUMENTATION)

_____

LEGAL CUSTODIAN/GUARDIAN: (PROVIDE DOCUMENTATION)

_____

RELATIONSHIP: _____ PHONE: _____

EMAIL: _____

ADDRESS: _____

HAVE PARENTAL RIGHTS BEEN TERMINATED? _____

IF YES, □ MOTHER □ FATHER DATE OF TERMINATION: _____

HAS CLIENT BEEN ADOPTED: _____ ADOPTION DATE: _____

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CLIENT'S SIBLINGS

NAME	AGE	RELATIONSHIP	LIVING ARRANGEMENT

MEDICAL

CURRENT MEDICAL ISSUES: _____

_____

PAST MEDICAL ISSUES/PROCEDURES: _____

_____

ALLERGIES/ADVERSE MEDICATION REACTIONS: _____

_____

PRIMARY CARE PHYSICIAN

AGENCY: _____

DOCTOR NAME: _____

ADDRESS: _____

PHONE: _____ DATE OF LAST PHYSICAL EXAM: _____

DENTIST

AGENCY: _____

DENTIST NAME: _____

ADDRESS: _____

PHONE: _____ DATE OF LAST DENTAL EXAM: _____

DOES CLIENT NEED/WEAR GLASSES ☐ NO ☐ YES

DATE OF LAST EYE EXAM: _____

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MENTAL HEALTH INFORMATION (PROVIDE DATES AND SPECIFIC DETAILS)

CURRENT DIAGNOSES:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

SUICIDAL/HOMICIAL IDEATION/GESTURE/ATTEMPTS

_____

_____

HISTORY OF PSYCHOSIS

_____

_____

HISTORY OF RUNAWAYS

_____

_____

DOES CLIENT REQUIRE A SEXUALLY REACTIVE PROGRAM: ☐ **YES** ☐ **NO**

HISTORY OF SEXUALIZED BEHAVIORS

_____

_____

FAMILY HISTORY OF MENTAL ILLNESS/SUBSTANCE ABUSE: ☐ **YES** ☐ **NO**

IF YES, DESCRIBE: _____

_____

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SIGNIFICANT DEVELOPMENTAL HISTORY ☐ **NONE KNOWN** ☐ **YES, EXPLAIN:**

_____

_____

_____

HISTORY OF CHEMICAL DEPENDENCY

TYPE	AMOUNT	FREQUENCY	AGE AT FIRST USE	LAST USE

CURRENT MEDICATIONS

MEDICATIONS	DOSAGE	FREQUENCY	COMPLIANT
			YES NO
			YES NO
			YES NO
			YES NO

PRESCRIBING PHYSICIAN NAME: _____

PHONE: _____

TREATMENT HISTORY (OUTPATIENT, INPATIENT, RESIDENTIAL, HOSPITALIZATIONS)

AGENCY/FACILITY	DATES

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CURRENT SYMPTOMS AND FUNCTIONING REQUIRING TREATMENT IN PRTF

_____

_____

_____

LEGAL ISSUES

CURRENT CHARGES: _____

PENDING COURT DATES/CHARGES: _____

_____

PROBATION OFFICER: _____

ADDRESS: _____

PHONE: _____ FAX: _____

COUNTY OF PROBATION: _____

IS CLIENT COURT ORDERED FOR TREATMENT ☐ NO ☐ YES, PROVIDE COURT PAPERS

ACADEMICS

ASSIGNED GRADE LEVEL: _____ RETAINED IN WHAT GRADE: _____

IQ: _____ LAST SCHOOL ATTENDED: _____

DOES CLIENT HAVE CURRENT IEP: ☐ NO ☐ YES, ATTACH COPY OF IEP

EDUCATIONAL SETTING: ☐ REGULAR CLASS ☐ SPECIAL EDUCATION ☐ HOME BOUND

☐ GED PROGRAM ☐ OTHER, EXPLAIN: _____

HAS CLIENT BEEN CLASSIFIED AS SPECIAL NEEDS UNDER PL 105-17: ☐ NO ☐ YES

IF YES, WHAT SPECIAL NEED(S): _____

HAS CLIENT BEEN SUSPENDED/EXPELLED IN LAST SCHOOL YEAR: ☐ NO ☐ YES

IF YES, WHY: _____