CAROLINA DUNES BEHAVIORAL CENTER
ADMISSION APPLICATION

PERSON/AGENCY MAKING APPLICATION:

AGENCY NAME REFERRAL:______________________________

NAME:______________________________

ADDRESS: ______________________________

CITY, STATE, ZIP:______________________________

PHONE:______________________________

FAX:______________ EMAIL: ______________

POTENTIAL CLIENT:

NAME:______________________________

ADDRESS: ______________________________

CITY, STATE, ZIP:______________________________

PHONE:______________________________

COUNTY:______________ LME/MCO CONTACT PERSON:______________

LME/MCO:______________ LME/MCO #:______________

DOB:________ AGE: ______ GENDER:______ RACE:________

HEIGHT : ______ WEIGHT:______ SS#:______________

FINANCIAL INFORMATION: (ATTACH COPY OF INSURANCE CARD)

MEDICAID #:______________ HEALTH CHOICE#:______________

OTHER INSURANCE COMPANY NAME:______________________________

INSURANCE CO. ADDRESS:______________________________

INSURED (MEMBER) NAME:______________ SS#:______________

GROUP#: ______________ PLAN#:______________

SUBSCRIBER#: ____________________ INSURANCE CO. PHONE#: ________________________________

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 THE LAST 30 DAYS: __________

____

CUSTODY: ☐ PARENTS ☐ DSS ☐ OTHER: ____

MOTHER'S NAME: ____

ADDRESS: ____

PHONE: _________________________________ EMAIL ADDRESS: ___________________________

MARITAL STATUS: __________________ SPOUSE'S NAME: ___________________________________

FATHER'S NAME: ____

ADDRESS: ____

PHONE: _________________________________ EMAIL ADDRESS: ___________________________

MARITAL STATUS: __________________ SPOUSE'S NAME: ___________________________________

IF PARENTS ARE DIVORCED/UNMARRIED, WHAT IS CUSTODY ARRANGEMENT? ____________

____ (Provide documentation)

LEGAL CUSTODIAN/GUARDIAN: (PROVIDE DOCUMENTATION)

RELATIONSHIP: __________________________________ EMAIL: ______________________________

ADDRESS: ____

PHONE:______________________ HAVE PARENTAL RIGHTS BEEN TERMINATED?________ IF YES,

☐ MOTHER ☐ FATHER DATE OF TERMINATION: ______________________________________

HAS CLIENT BEEN ADOPTED?_________________ DATE OF ADOPTION:____________________

CLIENT'S SIBLINGS:

NAME	AGE	RELATIONSHIP	SIBLING LIVES WITH WHOM?

MEDICAL:

CURRENT MEDICAL ISSUES (Ex Diabetes, Asthma, Seizures):

____

PAST MEDICAL ISSUES/SURGERIES:

____

ALLERGIES/ADVERSE MEDICATION REACTIONS:

____

PRIMARY CARE PHYSICIAN:

NAME:____

ADDRESS:____

PHONE:____

DATE OF LAST PHYSICAL EXAM:____

DENTIST:

NAME:____

ADDRESS:____

PHONE:____

DOES CLIENT HAVE BRACES: ☐YES ☐ NO

DATE OF LAST DENTAL EXAM:______________________________

DOES CLIENT NEED/WEAR GLASSES: ☐YES ☐ NO

DATE OF LAST EYE EXAM:________________________

MENTAL HEALTH INFORMATION (PROVIDE DATES AND SPECIFIC DETAILS)

CURRENT DIAGNOSES (Include F Codes if possible, for Mental Health Disorders, Personality Disorders, Medical Diagnosis, Social/Environmental Concerns):

____

____

____

SUICIDAL/HOMICIDAL IDEATION/GESTURE/ATTEMPTS:

____

____

HISTORY OF PSYCHOSIS: ☐YES ☐ NO
If yes, indicate Auditory, Visual, Command, Paranoia, Delusions:

____

____

HISTORY OF ABUSE TOWARD CLIENT: ☐YES ☐ NO
If yes, indicate Physical, Emotional, Sexual, or Neglect:

____

____

HISTORY OF ELOPEMENTS/RUN:

____

____

DOES THE CLIENT REQUIRE A SEXUALLY REACTIVE PROGRAM ☐YES ☐ NO

HISTORY OF SEXUALIZED BEHAVIORS:

____

____

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

IF YES DESCRIBE:____

.

____

SIGNIFICANT DEVELOPMENTAL HISTORY: ☐YES ☐ NO
If yes, describe:

____

____

____

HISTORY OF AUTISM SPECTRUM DSORDER: ☐YES ☐ NO

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 AND PHONE NUMBER:_________________________

TREATMENT HISTORY (OUTPATIENT, INPATIENT, RESIDENTIAL, HOSPITALIZATIONS)

AGENCY/ FACILITY	DATES

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:☐ YES ☐ NO (PROVIDE COURT PAPERS)

ACADEMICS:

ASSIGNED GRADE LEVEL: RETAINED IN WHAT GRADE?

IQ:____________ LAST SCHOOL ATTENDED:____

DOES CLIENT HAVE A CURRENT IEP? ☐YES ☐ NO (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? ? ☐YES ☐ NO

IF SO, WHAT SPECIAL NEED(S)?____

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

IF YES WHY:____

ADDITIONAL INFORMATION:

CURRENT OR HISTORY OF ANGER/AGGRESSION?

☐YES ☐ NO

If yes, indicate severity, if they destroy property, physical/verbal, if at home, school, or both:

____

____

CURRENT OR HISTORY OF DEPRESSION?

☐YES ☐ NO

If yes, what are their symptoms:

____

____

CURRENT OR HISTORY OF SELF INJURIOUS BEHAVIORS?

☐YES ☐ NO

If yes, method, how often, last incident, and where:

____

____

CURRENT OR HISTORY OF ANXIETY?

☐YES ☐ NO

If yes, describe cause, if they have panic attacks, and symptoms:

____

____

PROBLEMS WITH AVERAGE DAILY ACTIVITIES (hygiene, sleeping, eating, etc.)?

☐YES ☐ NO

If yes, what areas are of concern. Also, are they a fall risk?

____

____

DESCRIBE HISTORY OF FAMILY'S INVOLVEMENT IN TREATMENT

____

____

____

ADDITONAL MEDICAL INFORMATION:

DOES THE CLIENT REQUIRE CRUTCHES, WHEELCHAIR, ETC.?

☐YES ☐ NO

DO THEY HAVE ANY STICHES OR REQUIRE WOUND CARE?

☐YES ☐ NO

DOES THE CLIENT HAVE AN ACTIVE RASH?

☐YES ☐ NO

DOES THE CLIENT HAVE STREP?

☐YES ☐ NO

DOES THE CLIENT HAVE LICE?

☐YES ☐ NO