**SOUTHERN PEAKS REGIONAL TREATMENT CENTER**

**INITIAL REFERRAL FORM**

**IT IS IMPORTANT THAT ALL INFORMATION REQUESTED ON THESE FORMS IS COMPLETE**

**Referral Date:** Click here to enter a date.

**Referral Agency**: Click here to enter text. **State**: Click here to enter text.

**Referral Agent’s Name**: Click here to enter text.

**Phone#:**Click here to enter text. **Email**: Click here to enter text.

**Referral Agent’s Address**: Click here to enter text.

**Requested Program Placement: (Check all that apply)**

Behavioral Health [ ]  Medicine Bear [ ]

Haven/ Sexually Exploited [ ]  Journey/ Substance Abuse [ ]

Sexual Misconduct

Insight (Male) [ ]  Renew (Female) [ ]

Don’t Know [ ]

**Youth’s Name**: Click here to enter text. Height: Click here to enter text. Weight: Click here to enter text.

Gender: Choose an item. Social Security#: Click here to enter text.

DOB: Click here to enter text. Medicaid/Insurance#: Click here to enter text.

Race: Choose an item. Ethnicity: Choose an item.

Who has custody/guardianship: Click here to enter text.

**Current Residence or Placement**:

Type: Click here to enter text. Name: Click here to enter text.

Address: Click here to enter text. Phone: Click here to enter text.

**Parents/ Guardian**

Name: Click here to enter text. Relationship to youth: Click here to enter text.

Address: Click here to enter text. Phone#: Click here to enter text.

Alt. Phone#: Click here to enter text. Email: Click here to enter text.

**Funding Source**: Choose an item.

Primary Insurance Name: Number:

Secondary Insurance Name: Number:

**ATTACH A COPY OF MEDICAID CARD OR PRIVATE INSURANCE CARD**

**MCO Care Coordinator (if applicable):**

Name: Click here to enter text. Phone Number: Click here to enter text.

Email: Click here to enter text.

**Education Information:**

Name of Last School Attended: Click here to enter text.

Address: Click here to enter text.

Name of Home School District: Click here to enter text.

Current Grade: Click here to enter text.

I.Q.:

IEP: 

Education Funding Source: 

**Discharge/ Aftercare Plan:**

Location of Discharge: Click here to enter text.

Type of Placement: Click here to enter text.

Living Options: Click here to enter text.

Other: Click here to enter text.

Admission Screening Questions

***If answer is “YES” to any of the questions below, please provide a detailed explanation.***

1. Primary reason client is being referred to this level of care?

Click here to enter text.

1. Does the client have hallucinations and/or delusions?

Click here to enter text.

1. Does the client have an IQ below 70? Click here to enter text.
	1. Other mental health or developmental concerns? Click here to enter text.
2. Has the client had suicidal ideations or an attempt? Click here to enter text.
	1. How many times has client been hospitalized for SI or attempts? Click here to enter text.
	2. How often are ideations? Click here to enter text.
		1. When was the last ideation? Click here to enter text.
	3. How many attempts? Click here to enter text.
		1. When was the last attempt? Click here to enter text.
		2. What did the attempt look like? Click here to enter text.
3. Is the client physically violent? Click here to enter text.
	1. Is client assaultive towards family, peers, and/or staff? Click here to enter text.
	2. If so, what does the aggression look like? Click here to enter text.
	3. How often is the client assaultive? Click here to enter text.
	4. When was the last time client assaulted someone? Click here to enter text.
	5. Are there legal issues associated with violence? Click here to enter text.
4. Does the client have a history of sexually maladaptive behaviors? Click here to enter text
	1. Has the client ever been charged with a sexual offense? Click here to enter text.
5. Does the client have gang affiliation? Click here to enter text.
	1. What gang? Click here to enter text.
	2. Charges related to gang affiliation? Click here to enter text.
	3. Violence related to gang affiliation? Click here to enter text.
6. Is client currently on probation? If so, please provide the reason(s) client is on probation; and the name, email, and phone number of PO. Click here to enter text.
7. Does youth currently have pending charges? If yes, please explain Click here to enter text.
8. Please note any medical conditions: Click here to enter text.
9. Please list all medications client is currently taking: Click here to enter text.
10. Has client been placed in residential treatment previously? Click here to enter text.
	1. If yes, name of facility and dates? Click here to enter text.
	2. Did youth successfully discharge? Click here to enter text.
11. Has client previously participated in outpatient treatment? Click here to enter text.
	1. If yes, please list provider and dates

 Click here to enter text.

1. Has client been placed in inpatient Hospitalization? Click here to enter text.
	1. Dates and reasons for hospitalization:

Click here to enter text.

1. Has youth agreed to admission in an RTC, and is youth willing to participate in treatment?

 Click here to enter text.

**Colorado Referrals:**

* **Family Service Plan/ Discrete Case Plan**
* **Mitimus (DYS referrals only)**

**PLEASE INCLUDE THE MOST CURRENT CLINICAL AND BEHAVIORAL INFORMATION, such as:**

Evaluations:

 Psychological Evaluation

 Psychiatric Evaluation

 Drug and Alcohol Evaluation

 Other Evaluation (If applicable)

Past Placement Discharge Summaries

 Family Service Plan

 Court Reports

 Court Orders

 Discrete Case Plan

 Offense History

**PLEASE COMPLETE AND SUBMIT REFERRAL FORM & ADMISSIONS SCREENING QUESTIONS WITH DOCUMENTATION TO:**

EMAIL: ADMISSIONS@SOUTHERNPEAKSRTC.ORG

OR

FAX: 719-362-5078

**CONTACT INFORMATION:**

Jeremy Hugins Judith Arciniaco jhugins@abraxasyfs.org jarciniaco@abraxasyfs.org

719-318-6495 303-746-9269

**UPON ACCEPTANCE OF YOUTH THE FOLLOWING DOCUMENTS MUST BE SUBMITTED:**

Signed Consent Forms

Birth Certificate

Social Security Card

Immunization Records

Medicaid/ Insurance Card

IEP (If appropriate)