Bassett House
Where change and recovery begin

The Residential Treatment Facility for Adolescents

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PRE-ADMISSION INFORMATION

PERSON FILLING OUT THIS FORM:______________________DATE:_______________

FIRST NAME: __________________________ MIDDLE NAME: ________________
LAST NAME: __________________________ SOC SEC #: ______________________
DOB: _________________________________ AGE: ___________________________
RACE: (OPTIONAL)_____________________ HEIGHT: ________________________
WEIGHT: ______________________________ HAIR COLOR: ___________________
EYE COLOR: ___________________________ GENDER: M OR F

CASE ADDRESS RECORD

ADDRESS: ____
CITY: _____________________________ STATE: __________________ZIP: _____________
PHONE #: __________________________COUNTY OF RESIDENCE______________________

PARENTS LIVING RECORD

MOTHER'S NAME: ____
MOTHER'S ADDRESS: ____
CITY: ______________________________ STATE: _________________ZIP:______________
PHONE #: ___________________________

FATHER'S NAME: ____
FATHER'S ADDRESS: ____
CITY: ______________________________ STATE: _______________ZIP: _______________
PHONE #: __________________________

CUSTODY INFORMATION

WHO HAS CUSTODY OF YOUTH? ____
ADDRESS OF CUSTODIAN: ____
CITY: ______________________________ STATE: _______________ZIP: ______________
PHONE #: __________________________

REFERRAL RECORD

WHO IS REFERRING YOUTH?: ____
NAME AND /OR AGENCY:____
ADDRESS: ____
CITY:______________________________STATE:___________ZIP:____________________
PHONE #: __________________________
PRIOR REFERRAL FROM THIS AGENCY?: ____
WHAT CRISIS PRECIPITATES THIS REFERRAL?_____________________________________
____
IS THE YOUTH PREGNANT?____
IS YOUTH CURRENTLY AN I.V. DRUG USER? Y OR N

LEGAL INFORMATION

ON PROBATION? Y OR N ARE CHARGES PENDING? Y OR N
ARE CHARGES RELATED TO DRUG /ALCOHOL USE? Y OR N
COURTNAME: ____
COURT ADDRESS: ____
CITY: ____________________STATE:__________ZIP:______________
PHONE #: ____________________EMERGENCY COURT CONTACT #?__________
PROBATION OFFICER: _________________________COURT ORDERED? Y OR N
CONSEQUENCES IF TREATMENT NOT COMPLETED:_____________________
____

PREVIOUS MISDEMEANORS:___________________________________
PREVIOUS FELONIES_______________________________________
OF TIMES IN DETENTION CENTER: _____ VALID DRIVERS LICENSE: Y OR N
IS YOUTH IN NEED OF PLACEMENT BECAUSE OF DUI? Y OR N
OF DUI ARRESTS: __________ IS YOUTH A RUNAWAY RISK? Y OR N

PAST ALCOHOL/DRUG INPATIENT/RESIDENTIAL TREATMENT

OF PAST INPATIENT/RESIDENTIAL TREATMENT EPISODES: ______________
DISCHARGE DATE(S):_______________________________________
NAME OF FACILITY TREATED MOST RECENTLY: ____________________
ADDRESS: ____
CITY: ___________________ STATE: ______________ ZIP: ______________
PHONE #: _________________ NAME OF THERAPIST: __________________
DATE(S) OF ATTENDANCE:__________COMPLETED SUCCESSFULLY? Y OR N

PAST ALCOHOL/DRUG OUTPATIENT TREATMENT

OF PAST OUTPATIENT TREATMENT EPISODES: _____________________
NAME OF FACILITY TREATED MOST RECENTLY: ____________________
ADDRESS: ____
CITY: ___________________STATE: ________________ZIP: ____________
PHONE #: ________________ NAME OF THERAPIST: __________________
DATE(S) OF ATTENDANCE: _________COMPLETED SUCESSFULLY? Y OR N

PAST MENTAL HEALTH TREATMENT

OF PAST MENTAL HEALTH SERVICES: _________LAST DISCHARGE DATE: ____
INPATIENT OR OUTPATIENT?_______________________________________
NAME OF PROGRAM TREATED MOST RECENTLY: ____________________
ADDRESS: ____
CITY: _________________STATE: ________________ZIP: ______________
PHONE #: ______________
PROVIDER OF PSYCHIATRIC/PSYCHOLOGICAL SERVICES: _______________
DIAGNOSIS: ____
MEDICATION FOR CURRENT PSYCHIATRIC ILLNESS: ___________________

ABUSE INFORMATION

WAS YOUTH: (CIRCLE ALL THAT APPLY)
SEXUALLY ABUSED? Y OR N VICTIM PERPETRATOR WITNESS
PHYSICALLY ABUSED? Y OR N VICTIM PERPETRATOR WITNESS
DOMESTIC VIOLENCE? Y OR N VICTIM PERPETRATOR WITNESS

EMERGENCY CONTACTS

EMERGENCY CONTACT NAME # 1: ____
ADDRESS: ____
CITY: ___________________________ STATE: __________________ ZIP: ____________
PHONE #: ________________________ RELATIONSHIP TO YOUTH:_________________
EMERGENCY CONTACT NAME #2: ____
ADDRESS: ____
CITY: ____________________________STATE: __________________ZIP: ____________
PHONE #: _________________________ RELATIONSHIP TO YOUTH:_________________

SCHOOL INFORMATION

IS YOUTH CURRENTLY AN ACTIVE STUDENT?_________________________________
HOME SCHOOL DISTRICT: ____
DISTRICT ADDRESS: ____
CITY: _________________________STATE: ___________________ZIP: _________________
PHONE #: ______________________
SCHOOL NAME: ____
SCHOOL ADDRESS: ____
CITY: ___________________________STATE: __________________ZIP: _______________
PHONE #: ________________PRINCIPAL/COUNSELOR'S NAME:___________________
IEP Y OR N SPECIAL EDUCATION? Y OR N LEARNING DISABILITY CLASSES?YOR N
DROPOUT? Y OR N LAST GRADE COMPLETED?__________GPA:___________
SUSPENSIONS? Y OR N EXPLAIN:____
EXPULSIONS? Y OR N EXPLAIN:____
SCHOOL ACTIVITIES: ____
PEER GROUP INFORMATION:____
IF YOUTH IS BETWEEN THE AGES OF 16 AND 18. DO YOU GIVE PERMISSION FOR CLIENT TO WORK TOWARDS G.E.D.? Y OR N

FAMILY HISTORY

MOTHER LIVING/DECEASED?__________ AGE: __________SSI BENEFITS:___________
DATE OF DEATH:__________AGE AT DEATH:____________ ALCOHOL/DRUG USE?___
FATHER LIVING/DECEASED? _________ AGE: ___________SSI BENEFITS:___________
DATE OF DEATHE: ________AGE AT DEATH:____________ ALCOHOL/DRUG USE?___
SIBLINGS LIVING/DECEASED?__________AGE: __________SSI BENEFITS:___________
DATE OF DEATH: _________AGE AT DEATH: ____________ALCOHOL/DRUG USE?____
SIBLINGS LIVING/DECEASED?__________AGE: __________SSI BENEFITS:___________
DATE OF DEATH:_________AGE OF DEATH:_____________ALCOHOL/DRUG USE:____

PRIMARY DRUG RECORD
SUBSTANCE TYPE:____
FREQUENCY OF USE:____
ROUTE OF ADMINISTRATION:____________________AGE AT FIRST USE:___________
LAST USE (IF KNOWN)___________POTENTIAL FOR WITHDRAWAL:_______________

SECONDARY DRUG USE
SUBSTANCE TYPE:____
FREQUENCY OF USE:____
ROUTE OF ADMINISTRATION:____________________AGE AT FIRST USE:____________
LAST USE (IF KNOWN)_______________POTENTIAL FOR WITHDRAWAL:___________

OTHER DRUG RECORD
SUBSTANCE TYPE:____
FRQUENCY OF USE:____
ROUTE OF ADMINISTRATION:____________________AGE AT FIRST USE:____________
LAST USE (IF KNOWN)_______________POTENTIAL FORWITHDRAWAL:____________

MEDICAL INFORMATION
PLEASE LIST ALL MEDICATIONS YOUTH IS CURRENTLY TAKING:________________
____
HAS YOUTH EVER OVERDOSED? Y OR N ON WHAT?____________________________________
ACCIDENTAL? Y OR N
SERIOUS HEAD INJURY:Y OR N MIGRAINE'S: Y OR N ULCERS: Y OR N ASTHMA: Y OR N
SEIZURES: Y OR N IF YES WHEN WAS LAST EPISODE?_________________________
DENTAL PROBLEMS:____
PHYSICAL DISABILITIES:____
DIETARY RESTRICTIONS:____
FOOD ALLERGIES:____
EATING DISORDER Y OR N ANEXORIA Y OR N BULIMIA Y OR N
ALLERGIES TO MEDICATIONS:____
ENVIROMENTAL ALLERGIES:____
CHILDHOOD ILLNESS:____
BIRTH CONTROL: Y OR N PREGNANT: Y OR N STD'S: Y OR N
IF PREGNANT HOW FAR ALONG?__________# OF PREGNANCIES:__________________
OF BIRTHS:_________________HAS YOUTH BEEN USING WHILE PREGNANT:______
IF YES WHAT WAS THE SUBSTANCE TYPE:____
IF YOUTH IS MALE IS HE A FATHER? Y OR N NUMBER OF CHILDREN____________
BROKEN BONES/FRACTURES:____
HEART MURMURS OR HEART CONDITIONS:____
IMMUNIZATION RECORD ATTACHED? Y OR N
TUBERCULOSIS (TB) MANTOUX SKIN TEST ATTACHED? Y OR N
HAS YOUTH HAD LICE IN THE PAST 6 MONTHS? Y OR N
WAS IT TREATED? Y OR N HAS IT REOCURED? Y OR N

MENTAL HEALTH INFORMATION

HAS YOUTH ATTEMPTED SUICIDE: Y OR N # OF ATTEMPTS:___________________
MOST RECENT ATTEMPT:____________________ATTEMPT METHOD:_______________
WAS YOUTH TAKEN TO EMERGENCY ROOM? Y OR N
WAS YOUTH ADMITTED AS AN INPATIENT DUE TO SUICIDE ATTEMPT? Y OR N
IS YOUTH NOW STABLE? Y OR N
CURRENT SUICIDE POTENTIAL RISK: ____
DOES YOUTH HAVE A SUICIDE PLAN? Y OR N
IS YOUTH DEPRESSED? Y OR N DUAL DIAGNOSIS: Y OR N ADHD: Y OR N
LEARNING DISABILITY? Y OR N ANXIETY DISORDER? Y OR N
THOUGHT DISORDER? Y OR N MOOD DISORDER? Y OR N
PSYCHOLOGICAL/PSYCHIATRIC DIAGNOSIS:___________________________________
DIAGNOSED BY: ____
CURRENT MENTAL HEALTH MEDICATIONS:____________________________________

HOSPITAL/PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN'S NAME:____
ADDRESS: ____
CITY:______________________STATE:__________________ZIP:_______________________
PHONE#:___________________
PREVIOUS MEDICAL TREATMENT WITHIN LAST 24 MONTHS: ____________________
____
HOSPITAL NAME:____
ADDRESS:____
CITY:______________________STATE:__________________ZIP:_______________________
PHONE #:_______________TREATING DOCTOR:______________________________

VIOLENT BEHAVIOR RECORD

DOES YOUTH HAVE A HISTORY OF VIOLENT BEHAVIOR?: Y OR N
IF YES, IS BEHAVIOR RELATED TO A MENTAL HEALTH DIAGNOSIS? Y OR N
IF YES WHEN WAS LAST EPISODE?____
TYPE OF VIOLENT BEHAVIOR:____
TO FAMILY: Y OR N PEERS: Y OR N STRANGERS:Y OR N ANIMALS: Y OR N
HISTORY OF STARTING FIRES? Y OR N WERE CHARGES FILED? Y OR N
WHEN?__________________________________WHERE?_____________________________
IS YOUTH AN ASSAULT RISK: Y OR N
IS YOUTH CURRENTLY TAKING MEDICATION FOR THIS BEHAVIOR: Y OR N
IS YOUTH STABLE NOW: Y OR N
*IF HISTORY OF VIOLENT BEHAVIOR OR FIRE STARTING PLEASE DESCRIBE THE EVENT (WHEN, WHERE AND WHAT HAPPENED)?____
____
ANY ADDITIONAL INFORMATION:____
____

THIS SECTION MUST BE COMPLETED IN ITS ENTIRETY

MEDICAID INFORMATION

DOES YOUTH HAVE MEDICAID? Y OR N
IF YES, MEDICAID BILLING NUMBER:____
NAME OF COUNTY THAT ISSUED THE MEDICAID NUMBER:______________________
IF YOUTH DOES NOT HAVE MEDICAID, WHO WILL APPLY?______________________

INSURANCE INFORMATION

NAME OF ***PRIMARY*** INSURANCE COMPANY?____________________________________
ADDRESS OF INSURANCE COMPANY:____
PHONE NUMBER(S) OF INSURANCE COMPANY:__________________________________
PRE-AUTHORIZATON PHONE NUMBER:____
MENTAL HEALTH/SUBSTANCE ABUSE PHONE NUMBER:_________________________
POLICYHOLDER/SUBSCRIBER:____
POLICYHOLDER/SUBSCRIBER ADDRESS:_______________________________________
POLICYHOLDER/SUBSCRIBER PHONE NUMBER:_________________________________
POLICYHOLDER RELATIONSHIP TO YOUTH:____________________________________
POLICYHOLDER SOCIAL SECURITY NUMBER:__________________________________
POLICYHOLDER DATE OF BIRTH:____
GROUP NUMBER:_________________________PLAN NUMBER:______________________
NAME OF EMPLOYER:____
____
PHONE NUMBER OF EMPLOYER:____
ADDITIONAL INFORMATION:____

NAME OF SECONDARY INSURANCE:____
ADDRESS OF INSURANCE COMPANY:____
PHONE NUMBER(S) OF INSURANCE COMPANY:__________________________________
MENTAL HEALTH/SUBSTANCE ABUSE PHONE NUMBER:_________________________
POLICYHOLDER/SUBSCRIBER ADDRESS:_______________________________________
____
POLICYHOLDER/SUBSCRIBER PHONE NUMBER:_________________________________
POLICYHOLDER RELATIONSHIP TO YOUTH:____________________________________
POLICYHOLDER SOCIAL SECURITY NUMBER:__________________________________
POLICYHOLDER DATE OF BIRTH:____
GROUP NUMBER:____________________________PLAN NUMBER:___________________
NAME OF EMPLOYER:____
ADDRESS OF EMPLOYER:____
____
PHONE NUMBER OF EMPLOYER:____
ADDITIONAL INFORMATION:____