The Residential Treatment Facility for Adolescent Males

Bassett House
Where change and recovery begin

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PRE-ADMISSION INFORMATION

PERSON FILLING OUT THIS FORM:_____DATE:_____

Youth's First Name: _____ Middle Name: _____

Youth's Last Name: _____ SOC SEC #: _____

DOB: _____ Age: _____
Race: (OPTIONAL)_____ Height: _____
Weight: _____ Hair Color: _____
Eye Color: _____ Gender: M OR F

IS YOUTH CURRENTLY USING IV_____ IS YOUTH PREGNANT _____

Does youth have children: _____ If so please list names and ages: _____
_____

REFERRAL RECORD

Who is referring youth: _____
Agency:_____
Address: _____
City:_____ State:_____ Zip:_____ Phone # _____
List reason for referral to this level of care: _____
_____

YOUTH'S PRIMARY ADDRESS

Name of person youth lives with: _____
Relationship to youth: _____
Address: _____
City: _____ State: _____Zip: _____
Phone #: _____County of residence _____

CUSTODY INFORMATION

Who has custody of youth: _____
Is there shared parenting: _____
Relationship to youth: _____
Address of custodian: _____
City: _____ State: _____Zip: _____
Phone number: _____

EMERGENCY CONTACTS

Emergency contact name: _____
Phone number: _____ Relationship to youth: _____

Emergency contact name: _____
Phone number: _____ Relationship to youth: _____

BIOLOGICAL PARENTS

Mother's name: _____
Mother's address: _____City: _____
State: _____Zip:_____ Phone number: _____

Father's name: _____
Father's address: _____City: _____
State: _____Zip:_____ Phone number: _____

ADOPTIVE/ FOSTER PARENTS

Mother's Name:_____
Mother's address: _____City: _____
State: _____Zip:_____ Phone number: _____

Father's Name: _____
Father's address: _____City: _____
State: _____Zip:_____ Phone number: _____

PRIMARY DRUG RECORD

Substance type: _____ Frequency of use: _____
Route of administration: By mouth_____ Snorting _____ Smoking _____IV _____
Age at first use: _____ Last Use: _____ Potential for withdrawal: _____

SECONDARY DRUG USE:

Substance type: _____ Frequency of use: _____
Route of administration: By mouth_____ Snorting _____ Smoking _____IV _____
Age at first use: _____ Last Use: _____ Potential for withdrawal: _____

OTHER DRUG RECORD

Substance type: _____ Frequency of use: _____
Route of administration: By mouth_____ Snorting _____ Smoking _____IV _____
Age at first use: _____ Last Use: _____ Potential for withdrawal: _____

Has youth received outpatient alcohol/drug treatment: _____

If not why:
_____

PAST ALCOHOL/DRUG OUTPATIENT TREATMENT

Number of past outpatient treatment episodes: _____
Name of facility treated at most recently: _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Name of counselor: _____ Beginning date of treatment: _____
Last date youth was seen: _____ Completed successfully: Y OR N
If not why: _____

PAST ALCOHOL/DRUG INPATIENT/RESIDENTIAL TREATMENT

Number of past inpatient/residential treatment episodes: _____
Name of facility treated at most recently: _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Name of counselor: _____ Beginning date of treatment: _____
Last date youth was seen: _____ Completed successfully: Y OR N
If not why: _____

LEGAL INFORMATION

Does youth have legal involvement: Y or N
On probation: Y OR N Are charges pending: Y OR N **Court ordered: Y OR N**
Consequences if treatment is not completed:_____
Court name: _____
Court address: _____ City: _____
State:_____ Zip:_____ Phone number: _____
Probation office: _____ Phone number: _____
Probation officer's emergency contact number: _____

Previous misdemeanors: _____
Previous felonies: _____
Number of times in detention center: _____

ABUSE INFORMATION

Sexually abused: Y OR N Age and sex of perpetrator: _____
Explain what abuse was: _____
_____

Has youth been charged in a sexual crime: Y OR N Explain:_____
_____

Physically abused: Y OR N Explain: _____
_____

Domestic violence: Y OR N Victim Perpetrator Witness
Explain: _____
_____

Has any of the above been reported: Y OR N If so to whom: _____

MENTAL HEALTH INFORMATION

Has youth attempted suicide: Y OR N

Number of attempts: _____Date of most recent attempt:_____
Attempt method:_____ Did youth need medical care: Y OR N
Was youth admitted as an inpatient due to suicide attempt: Y OR N
Is youth stable now: Y OR N
Current suicide risk: ___ Low ___Med. ___ High ____ Does youth have a suicide plan: ___
Has youth engaged in any type of self-harm: Y OR N
Nature of the harm: cutting ___ burning ___ breaking bones ___ other____
Explain _____
When was the last incident: _____
Has youth been diagnosed with a mental health disorder: Y OR N
List Diagnoses: _____
_____
Diagnosed by: _____
Current mental health medications: _____

PAST OUT PATIENT MENTAL HEALTH TREATMENT

Number of past mental health services: _____Last discharge date: _____
Name of program treated at most recently: _____ _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Provider of psychiatric/psychological services: _____
Diagnosis: _____
PAST INPATIENT MENTAL HEALTH TREATMENT
Number of past mental health services: _____ Last Discharge date: _____
Name of program treated at most recently: _____ _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Provider of psychiatric/psychological services: _____
Diagnosis: _____

VIOLENT BEHAVIOR RECORD

Does youth have a history of violent behavior: Y OR N If yes when was last episode: _____
If yes is behavior related to a mental health diagnosis: Y OR N
Type of violent behavior: _____
To Family: Y OR N Peers: Y OR N Strangers :Y OR N Animals: Y OR N
Is youth an assault risk at this time: Y OR N Is youth stable now: Y OR N
History of staring fires: Y OR N
When_____ Where_____

SCHOOL INFORMATION

Does youth attend: Regular School _____ ECOT _____ Home School _____ GED_____
Other educational program: _____
Do you give permission for youth to work towards a GED: Y OR N

School name: _____
School Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Principal/counselor's name: _____ Phone number _____
IEP Y OR N Special Education: Y OR N Learning disability classes: YOR N
Please list any learning disabilities: _____
Suspensions: Y OR N Explain: _____
Expulsions: Y OR N Explain: _____

MEDICAL INFORMATION

Please list all medications youth is CURRENTLY taking: _____
_____
Has youth ever overdosed: Y OR N Accidental: Y OR N
When and on What: _____
Serious head injury: Y OR N Explain: _____
List any serious/chronic medical issues: _____
_____
Seizures: Y OR N When was last episode: _____
Dental Problems: _____
Physical disabilities: _____
Dietary restrictions: _____
Food allergies: _____
Allergies to medications: _____

Eating Disorders: Y OR N Anorexia: Y OR N Bulimia: Y OR N
Is this current: Y OR N Is Youth medically stable : Y OR N

Birth control: Y OR N STD'S: Y OR N Explain _____
_____
Heart murmurs or heart conditions: Y OR N Describe:_____
Immunization record attached: Y OR N
Tuberculosis (TB) Mantoux Skin Test attached: Y OR N

HOSPITAL/PHYSICIAN INFORMATION

Does youth have a primary care physician: Y OR N
IF YES:
Primary Care Physician's Name:_____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
IF NO:
Where does youth receive medical care: _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Any major medical treatment within the last 24 months: Y OR N
Explain: _____
Name of Hospital: _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____

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: _____
If youth does not have Medicaid, who will apply? _____

INSURANCE INFORMATION

Name of primary insurance company: _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Pre-Authorization phone number: _____
Mental Health/substance abuse phone number: _____
Policy holder/subscriber: _____
Policy holder/subscriber: Address: _____
City_____ State: _____Zip: _____ Phone number: _____
Policy holder's relationship to youth: _____
Policy holder's SS #: _____ Policy holder's date of birth _____
Group number: _____Plan Number: _____
Name of employer: _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Additional information: _____

Name of secondary insurance company:_____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Pre-Authorization phone number: :_____
Mental Health/substance abuse phone number: _____
Policy holder/subscriber: _____
Policy holder/subscriber: Address: _____
City_____ State: _____Zip: _____ Phone number: _____
Policy holder's relationship to youth: _____
Policy holder's SS #: _____ Policy holder's date of birth _____
Group number: _____Plan Number: _____
Name of employer: _____
Address: _____ City_____
State: _____Zip: _____ Phone number: _____
Additional information: _____