



STRATEGIC BEHAVIORAL CENTER

ADMISSION APPLICATION

PERSON/AGENCY MAKING APPLICATION

AGENCY NAME: _____

REFERRAL NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

FAX: _____

POTENTIAL CLIENT

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

DOB: _____ AGE: _____ GENDER: _____

SSN: _____

RACE: _____

FINANCIAL INFORMATION

MEDICAID #: _____ (ATTACH COPY OF CARD)

OTHER INSURANCE COMPANY NAME: _____ (ATTACH COPY OF CARD)

INSURANCE CO. ADDRESS: _____

INSURED (MEMBER) NAME: _____ SS#: _____

GROUP#: _____ PLAN#: _____

SUBSCRIBER#: _____ INSURANCE CO. PHONE#: _____

LME: _____ LME#: _____

CURRENT PLACEMENT

LOCATION/AGENCY: _____

POINT OF CONTACT: _____

PHONE: _____ FAX: _____

LENGTH OF STAY: _____

REASON FOR NEED FOR NEW PLACEMENT: _____

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

CUSTODY

MOTHER'S NAME: _____

ADDRESS: _____

PHONE: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

FATHER'S NAME: _____

ADDRESS: _____

PHONE: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

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

_____ (provide documentation)

LEGAL CUSTODIAN: _____

RELATIONSHIP: _____

ADDRESS: _____

PHONE: _____

HAVE PARENTAL RIGHTS BEEN TERMINATED? _____ IF YES, WHEN? _____

HAS CLIENT BEEN ADOPTED? _____

DATE OF FINAL ADOPTION ORDER: _____

CLIENT'S SIBLINGS

NAME	AGE	RELATIONSHIP	SIBLING LIVES WITH WHOM?
------	-----	--------------	--------------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL

CURRENT MEDICAL ISSUES:

PAST MEDICAL ISSUES/SURGERIES:

ALLERGIES/ADVERSE MEDICATION REACTIONS:

HEIGHT: _____ WEIGHT: _____

PRIMARY CARE PHYSICIAN

NAME: _____

ADDRESS: _____

PHONE: _____

DATE OF LAST PHYSICAL EXAM: _____

DENTIST

NAME: _____

ADDRESS: _____

PHONE: _____

DATE OF LAST DENTAL EXAM: _____

DOES CLIENT NEED/WEAR GLASSES? _____ DATE OF LAST EYE EXAM? _____

MENTAL HEALTH INFORMATION (PROVIDE DATES AND SPECIFIC DETAILS)

CURRENT DIAGNOSES

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

SUICIDAL/HOMICIDAL IDEATION/GESTURE/ATTEMPTS

HISTORY OF PSYCHOSIS

HISTORY OF PHYSICAL/EMOTIONAL/SEXUAL ABUSE; NEGLECT

HISTORY OF RUNAWAYS

HISTORY OF SEXUALIZED BEHAVIORS

HISTORY OF CHEMICAL DEPENDENCY

TYPE	AMOUNT	FREQUENCY	AGE AT FIRST USE	LAST USE
------	--------	-----------	------------------	----------

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ACADEMICS

ASSIGNED GRADE LEVEL: _____ RETAINED IN WHAT GRADE? _____

IQ: _____ LAST SCHOOL ATTENDED: _____

DOES CLIENT HAVE CURRENT IEP? _____

EDUCATIONAL SETTING: REGULAR CLASS _____ SPECIAL EDUCATION _____ OTHER _____

HAS CLIENT BEEN CLASSIFIED AS SPECIAL NEEDS UNDER PL 105-17? _____

IF SO, WHAT SPECIAL NEED(S)? _____

HAS CLIENT BEEN SUSPENDED/EXPELLED IN LAST SCHOOL YEAR? _____ IF YES,

WHY? _____