

SpringBrook

BEHAVIORAL HEALTH SYSTEM

Please select which program you are requesting for your child or adolescent:

Psychiatric Residential Treatment Program (Standard)

OR

Psychiatric Intensive Diagnostic Residential Program (choose one of the following)*:

30 Day Assessment

60 Day Assessment

90 Day Assessment

Name of Patient

Signature of Guardian/Case Manager

Date

*If selecting the Intensive Diagnostic Program, please complete the following page.

*At SpringBrook we are dedicated to meeting the complex
mental health needs of children, adolescents, and adults in
a caring and nurturing environment.*



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www.springbrookbehavioral.com

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INTENSIVE DIAGNOSTIC RESIDENTIAL PROGRAM

PLEASE SKIP THIS PAGE IF REQUESTING STANDARD PRTE PLACEMENT

Client Name: _____

Referring Agency: _____

Days Approved (please check one): 30____ 60____ 90____

In order to best serve your child/adolescent, please provide a summary of behavioral issues that need to be addressed. We will create a battery of assessments that will provide insight into the specific behavioral needs of your child/adolescent.

Family Session Schedule:

- 1 time per month
- 2 times per month (every other week)
- Weekly

Are there any issues with families coming on weekdays during business hours?

YES **NO**

If **YES**, please explain:

CHILDREN'S SERVICES REFERRAL APPLICATION

Date of Referral: _____

Date Placement is Needed: _____

- Type of Referral:
- | | |
|--|--|
| <input type="checkbox"/> High Management | <input type="checkbox"/> Moderate Management |
| <input type="checkbox"/> Supervised Independent Living | <input type="checkbox"/> Intensive Crisis Care |
| <input type="checkbox"/> Residential Treatment Facility | <input type="checkbox"/> Therapeutic Foster Care – Level 1 |
| <input type="checkbox"/> Therapeutic Foster Care – Level 2 | <input type="checkbox"/> Therapeutic Foster Care – Level 3 |
| <input type="checkbox"/> Temporary De-escalation Care–Level 1 | <input type="checkbox"/> Temporary De-escalation Care–Level 2 |
| <input type="checkbox"/> Temporary De-escalation Care–Level 3 | <input type="checkbox"/> Temporary De-escalation Care–Level-HMGH |
| <input type="checkbox"/> Temporary De-escalation Care–Level-MMGH | <input type="checkbox"/> Other: _____ |

Referring Agency: COC DDSN DJJ DMH DSS DSS-MTS
 Other: _____

If client is in DSS custody, has the ISCEDC team approved placement? Yes No

Case Manager's Name: _____ Region: _____

Phone Number: _____ Fax Number: _____ E-Mail: _____

Address: _____

CLIENT INFORMATION

Client's Name: _____

Alias/Nickname: _____

Social Security Number: _____ Medicaid Number: _____

Medical Insurance Policy Carrier, Number(s), Holder: _____

Date of Birth: _____ Age: _____ Gender: _____ Race: _____ Height: _____ Weight: _____

Religious Affiliation: _____

Place of Birth: _____ County of Legal Custody: _____

Legal Custodian: _____ Relationship to Client: _____

Address: _____

Telephone Number: _____

Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.):

Hobbies:

CURRENT BEHAVIORAL PROBLEMS/WEAKNESSES (check all that apply): **If a behavior has an asterisk beside it, include an explanation of the circumstances/situation in the space below the chart.**

- | | | |
|---|--|---|
| <input type="checkbox"/> Abandonment Issues | <input type="checkbox"/> Aggressive (Physical) | <input type="checkbox"/> Aggressive (Sexual) |
| <input type="checkbox"/> Aggressive (Verbally) | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Antisocial Behavior |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> *Arson | <input type="checkbox"/> *Bedwetting |
| <input type="checkbox"/> Below Grade Level | <input type="checkbox"/> Cruelty to Animals | <input type="checkbox"/> Delusional |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Destroys Property | <input type="checkbox"/> Difficulty with Authority |
| <input type="checkbox"/> *Developmentally Delayed | <input type="checkbox"/> *Fire Setting | <input type="checkbox"/> Functionally Illiterate |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Loss/Grief Difficulties | <input type="checkbox"/> *Low IQ/Mental Retardation |
| <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Oppositional/Defiant | <input type="checkbox"/> Parental Neglect Issues |
| <input type="checkbox"/> Phobic Reactions/Behavior | <input type="checkbox"/> Physical Disability: | <input type="checkbox"/> Poor Coping Skills |
| <input type="checkbox"/> Poor Personal Hygiene | | <input type="checkbox"/> *Poor Reality Orientation |
| <input type="checkbox"/> Poor Social Skills | <input type="checkbox"/> Problems at School | <input type="checkbox"/> Running Away |
| <input type="checkbox"/> Self-Destructive Behavior | <input type="checkbox"/> *Sexually Acts Out | <input type="checkbox"/> Sexually Provocative |
| <input type="checkbox"/> Sibling Related Difficulty | <input type="checkbox"/> Suicidal Gestures | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Truancy | <input type="checkbox"/> Unruly/Ungovernable |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Explanation:

Client has been a victim of (check all that applies):

- | | | | | |
|----------------------------------|--------------------------------|-------------------------------------|---|-------|
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated-Perpetrator: | _____ |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated-Perpetrator: | _____ |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated-Perpetrator: | _____ |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated-Perpetrator: | _____ |

MEDICAL INFORMATION

DSM IV DIAGNOSIS:

<u>Source</u>	<u>Diagnosis</u>	<u>Date Given</u>
Axis I	_____	_____
Axis II	_____	_____
Axis III	_____	_____
Axis IV	_____	_____
Axis V	_____	_____

MEDICATIONS (list all current medications, dosages, and instructions):

<u>Medication Name</u>	<u>Dosage</u>	<u>Instructions</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any known, pre-existing medical conditions/physical disabilities that would place the client at a greater risk during restraint or seclusion.

Describe any known history of sexual or physical abuse that would place the client at greater psychological risk during restraint or seclusion.

MEDICAL CONDITIONS (check all that apply): C = Current; H = History of; T = Being Treated for

- | | | | | | |
|-----------|--|--------------|--|-------------|--|
| Anemia | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Anorexia | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Asthma | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Bulimia | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Chicken Pox | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Convulsions | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Diabetes | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Eczema | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Encopresis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Enuresis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Fainting | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Hay Fever | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Headaches | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Hepatitis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | HIV/AIDS | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Lice | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Measles | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Mumps | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Pink Eye | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Pregnancy | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Ringworm | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| Seizures | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Sinusitis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Sore Throat | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T |
| STD(s) | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | Tuberculosis | <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | | |

C H T Other: (specify) _____
C H T Other: (specify) _____
C H T Other: (specify) _____

Date of Last Physical Exam: _____ Dental Exam: _____ Eye Exam: _____

Dental Appliances: Yes No Contacts/Glasses: Yes No

Allergies: _____

Special Dietary Needs: _____

FAMILY INFORMATION

Biological Mother's Name: _____

Address: _____

Telephone Number: _____

Race: _____ Educational Level (if known): _____ Criminal Record: Yes No

Biological Father's Name: _____

Address: _____

Telephone Number: _____

Race: _____ Educational Level (if known): _____ Criminal Record: Yes No

Are the Biological Parents: Married Separated Divorced:
 Deceased (which one): _____ Other: _____

Have Parental Rights Been Terminated? No Yes date: _____

Name of Siblings:	Placement: (If applicable)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY STRENGTHS

FAMILY CONTACT

Significant Family Member(s) and Relationship to Client	Address	Phone Number	Type of Contact with Client (phone, letters, face-to-face, etc.)

OTHER APPROVED CONTACTS

Name and Relationship to Client	Address	Phone Number	Type of Contact with Client (phone, letters, face-to-face, etc.)

Are there any special conditions/restrictions for home visits or furloughs?

There is a family history of (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Child Abuse/Neglect | <input type="checkbox"/> Criminal Activity |
| <input type="checkbox"/> Inappropriate Sexual Behavior | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Treatment Disruption | <input type="checkbox"/> Other: _____ |

Brief family history on education, behavior, development, adoption, psychosocial, legal (arson, stealing, sexual, burglary, and assault), parent's psychiatric history, etc.

SCHOOL INFORMATION (CONFIDENTIAL AND NONTRANSFERABLE)

Client Name: _____
Date of Birth: _____ Gender: _____ Race: _____ Legal Custodian: _____
Agency: _____ Case Manager Name: _____
Agency Address: _____
Phone: _____ Fax: _____ E-Mail: _____

Home School District of Origin: _____

List last five schools attended beginning with the most recent:

PLACEMENT	DATES	SCHOOL ATTENDED	DELIVERY MODEL (Select from the list below.)

Delivery models are: Homebased, Itinerant, Medical Homebound, Regular Education, Resource Room, and Self-contained Classroom

Is client currently classified Special Education? No * Yes (Indicate primary classification below.) Unknown

- | | | |
|--|--|--|
| <input type="checkbox"/> Preschool Child with a Disability | <input type="checkbox"/> Deaf/Blindness | <input type="checkbox"/> Other Health Impairment |
| <input type="checkbox"/> Mental Disability | <input type="checkbox"/> Emotional Disability | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Specific Learning Disability | <input type="checkbox"/> Hearing Impairment/Deafness | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Speech or Language Impairment | <input type="checkbox"/> Multiple Disabilities | |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Orthopedic Impairment | |

- Has client ever been classified Special Education? No Yes Unk
- Does client have current IEP? No Yes Unk IF YES, date: _____
- Does client have section 504 Plan? No Yes Unk IF YES, date: _____
- Does client have history of truancy? No Yes Unk
- Has client ever been suspended? No Yes Unk
- Is client currently under recommendation for expulsion? No Yes Unk For what? (Enter the reason in the space below)

Is the client functioning at grade level? No Yes If below, please indicate grade level: _____

IQ/ACHIEVEMENT/ADAPTIVE TESTING

Name of Test	Date	Given By:	Scores and Ranges, e.g., Low. Average, etc.

Is the IQ score considered valid by the examiner? No Yes (If not, explain.) _____

Medical Conditions: _____

Current Medications: _____

This page is to be provided to the receiving school district along with the signed Authorization for Release of School Information

AGENCY/COURT INVOLVEMENT

AGENCIES CURRENTLY INVOLVED WITH CLIENT

CCRS COC DDSN DJJ DMH DSS DSS-MTS Voc. Rehab

Other: _____

Has the client ever been to court? No Yes-type of court and outcome:

Does the client have pending charges? No Yes-list charges:

Is placement court ordered? No Yes-attach copy of the order

TREATMENT GOALS

Client's Goals	
Family's Goals (if applicable)	
Agency's Goals	
Educational Goals	

**ADMISSION REQUIREMENTS CHECKLIST
(TO BE FORWARDED IF CLIENT IS ACCEPTED FOR PLACEMENT)**

The referring agency will make every reasonable effort to supply the items listed in the Admission Requirements Checklist if the client is accepted for placement. If more information than is provided in the Children's Services Referral Application is required to determine client eligibility for admission, the provider agency should request in writing the additional information from the referring agency.

ADMISSION REQUIREMENTS CHECKLIST (IF ACCEPTED FOR PLACEMENT)	
Medical Exam	
Most Recent Treatment Plan	
Current Medicaid /Insurance Card	
Medical Necessity Form	
254 Authorization Form	
Most Recent Psychological/Psychiatric Evaluation(s)	
Previous Placement Discharge Summary(ies)	
Individual Education Plan (if applicable)	
Copy of Birth Certificate	
Copy of Social Security Card	
Immunization Records	
Completed Consent Forms (Program should forward to referring agency prior to admission)	
Copies of Court Orders	
Signed Homebound Form (if applicable)	
Pre-Admission Assessment (if applicable)	

Name of Person Making Application: _____

Relationship to Client: _____ Telephone: _____

Address: _____

Signature: _____ Date: _____

Rationale: Requested by Providers, CM and DOE
