

WHITE HORSE ACADEMY RESIDENTIAL REFERRAL FORM

PRIORITY			
Code C (IV user)		Code D (all others)	
DEMOGRAPHICS			
Date Screen Completed:		Referral Source:	
Client Name (first, middle, last):			
Sex:	DOB:	SS#:	
Address:			
City:	County:	Zip:	
Parent/Guardian:		Relationship to Client:	
Home #:	Office #:	Cell #:	
REFERRING AGENCIES			
Agency	Case Worker	Phone Number	
REASON FOR REFERRAL			
PREVIOUS AOD HISTORY			
Substance(s) Used	Date Last Use	Amount & Frequency last 30 days	IV
Inpatient/Outpatient Facility Name		Year	Successful Completed
			No Yes
			No Yes

MENTAL HEALTH HISTORY				
Mental Health Diagnosis:				
Physician Name:		Date of Last Appointment:		
History of suicidal attempts: No Yes		Hospitalized: No Yes		
Explain:				
CRIMINAL HISTORY				
Currently on Probation? No Yes		Length of Probation:		
Agent Name:		Phone Number:		
Do you currently wear any type of electronic monitoring device? No Yes				
Any pending charges? No Yes, if so explain:				
History of Violence: No Yes, if so explain (charge & date):				
MEDICAL HISTORY				
Do you have any medical needs? No Yes				
Explain:				
Is the client HIV positive? No Yes				
Name of Medication	Dosage	Frequency	Date Last Dose	
Tuberculosis Risk Assessment			YES	NO
Have you ever been diagnosed with or treated for TB?				
Within the past 6 months, have you been around someone who has been diagnosed with or treated for TB?				
Within the past 6 months, have you traveled to or lived in any of the following countries: Latin America, the Caribbean, Africa, Asia, Eastern Europe, or Russia?				
Within the past 6 months, have you lived or worked in any of the following places: homeless shelter, jail, prison, or nursing home?				
Do you currently have any condition that weakens your immunity or ability to fight disease?				
Within the past 6 months, have you injected illegal or other drugs into your body which were not recommended by your doctor?				
Tuberculosis Current Symptom Survey			YES	NO
Have you had a cough for 3 weeks or longer which is much worse than a regular cough when you have a cold?				
Have you lost more than 5 pounds for no known reason?				

Have you coughed up blood?		
Have you experienced frequent, unexplained fever lasting for 2 weeks or more?		
Have you had unusual or heavy sweating, especially at night?		
Have you experienced weakness or extreme fatigue?		
MEDICAID/INSURANCE		
Medicaid Type: MCO	FFS	FPO
Medicaid Applied (date):	PA #:	
Other Insurance Company Name:		
Policy Holder Name:	Group #:	
Policy Holder SS #:	Policy Holder DOB:	
Policy Holder Employer:		
Benefits Tel. #:	Precertification Tel. #:	
Secondary Insurance:		
Total Family Income Amount:	weekly	bi-weekly monthly year
Total Number of People Living in House:		
SCHOOL INFORMATION		
Grade:	Date Last Attended:	
School Status:	Attending	Expelled Suspended Dropped Out
Name of Last School:		
County of Last School:		
ADMISSION ELIGIBILITY		
<p>To better assist The White Horse Academy staff in determining if this adolescent meets Inpatient Criteria, the following information should be faxed to (864) 371-1278 or mailed to Elizabeth Serricchio or Carmenlita Sayles.</p> <ul style="list-style-type: none"> • Most recent Clinical Assessment • Most recent Psychiatric/Psychological Evaluation • Last R & E Report • Copy of Medicaid/Insurance Card/W-2 form or Paycheck • Copies of all drug screens • Records from physician/agency prescribing medications 		
HIGH RISK - INFORMATION PROVIDED		
<p>All IV Users: Counseling and education about HIV and tuberculosis; Counseling and education about the risk of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and tuberculosis transmission does not occur; Referral for HIV or tuberculosis treatment services if necessary.</p> <p>Packet mailed: _____ Refused</p>		