BEHAVIORAL HEALTHCARE CORPORATION

……..lighting the way to new beginnings

PRTF Admission Application Packet

Date of Application:_____ **Date Service Needed:** _____

CONSUMER INFORMATION

Consumer's Name: _____ Nickname: _____ Race:_____

Social Security Number: _____ Date of Birth:_____ Age: _____ Sex_____

County: _____ MCO: _____

Type of Insurance: _____ _____
(Primary) *(Secondary)*

Medicaid Number**:**_____ Policy Number: _____

Consumer's Current Placement: _____How Long:_____

GUARDIAN INFORMATION

Legal Guardian _____

Relationship: _____County of Legal Custody: _____

Guardian's Address: _____

Guardian's Phone Number:_____

CONSUMER'S PRIMARY REFERRAL SOURCE INFORMATION

Referring Agency: _____

Address: _____City/State/Zip code: _____

Referring Contact: _____

Phone #:_____ Email: _____

Nova, PRTF (office use only)
Date of Review: _____
Decision: _____
If Denied, Reason:_____

CLINICAL/DIAGNOSTIC INFORMATION

DSM V Diagnosis/ Medical Diagnosis

Primary:_____

Additional:_____

Additional:_____

Additional:_____

Medical: _____

Additional: _____

IQ: _____ **Verbal** _____ **Performance**_____ **Full Scale** _____ **Please include any current evaluations/testing**

History of Abuse:
- ☐ Victim of Neglect
- ☐ Victim of Physical Abuse
- ☐ Victim of Sexual Abuse
- ☐ Victim of Emotional Abuse
- ☐ None

If checked please provide a written description. If DSS involvement please attach documentation._____
_____
_____
_____

Medications	Prescribing Physician	Dosage/Frequency	Date Started

MEDICAL INFORMATION

Allergies:_____

Special Dietary Needs: _____

Medical Conditions (past and present) Please note most recent occurrence:

☐ **Lice**	☐ **Bulimia**	☐ **Eczema**
☐ **Anemia**	☐ **Anorexia**	☐ **Asthma**
☐ **Drug/Alcohol Abuse**	☐ **Measles**	☐ **Hay Fever**
☐ **HIV/AIDS**	☐ **Mumps**	☐ **Convulsions**
☐ **Sexually Transmitted Disease**	☐ **Chicken Pox**	☐ **Sinus Problems**
☐ **Ringworm**	☐ **Sickle Cell Anemia**	☐ **Diabetes**
☐ **Tuberculosis**	☐ **Migraine Headaches**	☐ **Hepatitis**
☐ **Chronic Urinary / Bowel Problems**	☐ **Rubella**	☐ **Traumatic Brain Injury**
Other:_____	**Other:**_____	**Other:**_____

Name and Address of Pediatrician: _____

Name and Address of Dentist: _____

Date of Last Phys. Exam:_____ **Last Dental Exam:**_____ **Last Eye Exam:**_____

Dental Appliances: ☐ **Yes** ☐ **No** **Contacts/Glasses:** ☐ **Yes** ☐ **No**

ADDITIONIAL INFORMATION

STRENGTHS/ABILITIES/PREFERENCES

Strength/Capabilities _____
_____

Friendships/Social/Peer Support Relationships: _____
_____

Religion/Spirituality: _____

Cultural/Ethnic Issues/Information/Concerns: _____

Meaningful Activities (community involvement, volunteer activities, leisure recreation, other interests):_____
_____

Goals for Independent Living: _____
_____

PRESENTING PROBLEMS / REASON FOR REFERRAL

PLACEMENT HISTORY

Placement (Begin w/Current Placement)	Dates (From – To)	Reason for Discharge

CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS

Please describe behavior and include the date of last incident.

☐ **Abandonment Issues**	☐ **Anxiety**	☐ **Arson**
☐ **Alcohol/Drug Abuse**	☐ **Antisocial Behavior**	☐ **Stool/Feces smearing**
☐ **Assaultive (Physical)**	☐ **Assaultive (Sexual)**	☐ **Assaultive (Verbal)**
☐ **Bedwetting**	☐ **Eating Disorder**	☐ **Depression**
☐ **Property Destroying**	☐ **Fire Setter**	☐ **Developmental Disability**
☐ **Homeless**	☐ **Hyperactive**	☐ **Impulsive**
☐ **Lying**	☐ **Low Self-Esteem**	☐ **Loss/Grief Difficulties**
☐ **Physical Impairment**	☐ **Mental Retardation**	☐ **Parent Neglect Issues**
☐ **Perception of Reality**	☐ **Phobic Behavior**	☐ **Physical Disability**
☐ **Self Destructive Behavior**	☐ **Sibling Related Difficulty**	☐ **Oppositional**
☐ **Social Immaturity**	☐ **Sexually Inappropriate Behavior**	☐ **Stealing**
☐ **Suicidal**	☐ **Running Away**	☐ **Truancy**
☐ **Unruly/Ungovernable**	☐ **Cruelty to Animals**	☐ **Hygiene/Cleanliness Issues**
☐ **Problems with Sleep**	☐ **Gang Related Activity**	☐ **History w/ Weapons**

Other_____

ADDITIONAL INFORMATION

AGGRESSIVE OR VIOLENT BEHAVIOR ALERT

Please describe the nature of the acting out behaviors:

☐ **Verbally aggressive Frequency:_____**

Description:_____
_____
_____
_____

☐ **Physically aggressive Frequency:_____**

Description:_____
_____
_____
_____

☐ **Property destruction: Frequency: _____**

Description:_____
_____
_____
_____

Has the behavior resulted in injury to others? Criminal charges? Please describe:

Aggression is: ☐ impulsive ☐ planned

Where is the client aggressive:_____

Known triggers, please describe:

_____
_____
_____
_____

Main targets of aggression: □ Peers □ Authority figures □ Family members Please be specific:

Please describe the most recent episode of aggression:

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

FAMILY INFORMATION

Biological Mother's Name:_____

Address:_____

Telephone Number: Home: _____**Work:** _____ **Cell:** _____

Ethnicity _____ **Educ. Level:** ___ **Unknown** ____ **Criminal Record:** _____**(Yes/No) Unknown** _____

Biological Father's Name:_____

Address:_____

Telephone Number: Home: _____**Work:** _____ **Cell:** _____

Ethnicity _____ **Educ. Level:** ___ **Unknown** ____ **Criminal Record:** _____**(Yes/No) Unknown**

Are Parents: ☐**Married** ☐**Separated** ☐**Divorced** ☐**Never Married** ☐ **Deceased Mother** ☐ **Deceased Father**

Have parental rights been terminated: _____ **If so, who and when?** _____

How many siblings does Consumer have: _____

Age	Gender	Name	Age	Gender	Name
Age	**Gender**	**Name**	**Age**	**Gender**	**Name**

Are siblings in out-of-home placements? _____

If yes, please specify:

☐**DSS Foster Care** ☐**Relatives** ☐**Incarcerated** ☐**Group Home**

Other: _____

FAMILY DYNAMICS / FAMILY SOCIAL HISTORY

Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked please explain.

☐**Criminal Activity**	☐**Child Abuse**
☐**Inappropriate Sexual Behavior**	☐**Treatment Disruption**
☐**Psychiatric Illness**	☐**Substance Abuse**
☐**Suicide**	**Other:**

RESOURCES

Does the consumer have natural resources? (Parent/Guardian, DSS member, GAL)

Does the consumer have resources for home visits when appropriate? ☐ **Yes** ☐**No**
If so, who? _____

Are there any special conditions/restrictions for visits home? _____

_____

Any "no contact" orders? _____

_____

SCHOOL INFORMATION

Last School Enrolled: _____

County/District: _____ **Grade:** _____

Special Classes: ☐**EH** ☐**LD** ☐**Resource** ☐**BEH** _____
☐**Homebound** **Other:** _____

Any history of truancy? _____ **Grades Repeated:** _____

Current IEP? ☐**Yes** ☐**No** **Date:** _____

Current 504? ☐**Yes** ☐**No** **Date:** _____

Suspensions/Expulsions: _____

Choice of High School Curriculum: (if 16 or older) ☐**Regular** ☐**GED/High School Equivalent**

Special communication needs? ☐**Yes** ☐**No** _____

COURT HISTORY

Does Consumer have a criminal record? ☐**Yes** ☐ **No** **Tried as a** ☐ **Juvenile** ☐ **Adult**

Offenses : **Convictions:**
_____ _____
_____ _____
Pending Charges: _____

Is Consumer on Probation?_____ **Name of Court/Probation Officer**_____

Phone:_____ **Email address:**_____

Is placement court ordered? ☐**Yes** ☐**No** **(If "Yes, attach court order) Other information regarding court proceedings (next court date, if consumer is to appear:**

HISTORY OF SELF-INJURY AND RISK BEHAVIORS

Self Injury

Check all that apply ☐ cuts on body ☐ conceals cutting- indicate area
☐other forms of self injury (please describe)

Has self-injury ever required medical attention? Please explain: _____
_____

Suicidal Characteristics

Check all that apply ☐Suicidal thoughts ☐ Past Suicide Attempts ☐ Suicidal Plans

Describe:_____
_____

Methods used in previous attempts- please describe: _____

Homicidal Characteristics

Check all that apply ☐ homicidal thoughts ☐ Past Attempts to harm others ☐ Homicidal Plans

Describe: _____
_____

Methods used in previous attempts- please describe: _____

History of AWOL

☐ Runs away from home ☐ Has run from previous placements
In the past year how many times has consumer run? _____
Where does he/she go? _____

How long is typically AWOL? _____

Substance Abuse History

Type of Substance	Frequency	Last Use	Type of Substance	Frequency	Last Use
☐ Marijuana			☐ Amphetamines		
☐ Cocaine			☐ Hallucinogens		
☐ Heroin/Opiates			☐Alcohol		
☐ Inhalants			☐ Other:		

Sexualized Behaviors

Please describe any sexualized behaviors exhibited by consumer (i.e. exposure, sexual acting out, predatory behaviors, prostitution):_____
_____
_____
_____

Psychotic Behaviors

Please describe any past/present history of psychosis:_____
_____
_____
_____

REFERRAL CHECKLIST Please include the following information to help determine whether Nova, PRTF is the appropriate program for your consumer.	
Nova, PRTF Application	
Current Person Centered Plan / Sign Page	
Discharge Summaries from Hospitalizations/ Previous Treatment	
School Records/ IEP (if available)	
DSS records (if applicable)	
DJJ records (if applicable)	
Psychological Testing	
Sexually Aggressive Youth Evaluation / Sex Offender Specific Evaluation (if applicable)	
Immunization Records	
Birth Certificate	
Copy of Medicaid/ Insurance Cards	
Psychiatric evaluations	
Diagnostic Assessment (or any other assessment completed)	
Court/Custody Orders	

Please send all completed information to:

NOVA Behavioral Healthcare, PRTF

Kimberly Grady, LPN
Authorization/Admissions Specialist

*Email: kgrady@novaprtf.com

*Mailing address: PO Box 2277 Kinston, NC 28502

*Physical address: 2002 Shackleford Road Kinston, NC 28054

Office: (252)-233-0491 ext. 216
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