Highland Hospital

Bound For Success Program
Psychiatric Residential Treatment Facility

300 56th St. SE
Charleston, WV 25304
304-926-1607 or 304-925-1524

Referral Application

Child's Full Name:	**Today's Date: / /**
Date Referral Received (office use only):	
DOB: / /	☐ **Male** ☐ **Female**

RESIDENT INFORMATION			
Ethnicity:	**Language:**	**Religion:**	**Age:**
Current Placement - Address:		**Phone:**	**Ext:**
Discharge Plan:	**Physical Description:**		**HT:** **WT:**

BIOLOGICAL Mother's Information	**BIOLOGICAL Father's Information**
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
E-Mail:	**E-Mail:**
Place of Employment:	**Place of Employment:**
Is Parent Legal Guardian? ☐**Y** ☐**N** **Are Parental Rights Terminated?** ☐**Y** ☐**N** **Is Child Adopted?** ☐**Y** ☐**N** **Is Parent Involved?** ☐**Y** ☐**N** **Comment:**	**Is Parent Legal Guardian?** ☐**Y** ☐**N** **Are Parental Rights Terminated?** ☐**Y** ☐**N** **Is Child Adopted?** ☐**Y** ☐**N** **Is Parent Involved?** ☐**Y** ☐**N** **Comment:**
Parental Rights: **Physical Custody Only Y N Legal Custody Only Y N**	

LEGAL GUARDIAN INFORMATION	
Name/Relationship:	**Phone:**
Agency:	**Cell:**
Address:	**E-Mail:**

REFERRAL SOURCE INFORMATION		
Referral Source: ☐ **School** ☐ **Parent** ☐**Agency/County** ☐**Other**_____		
County of Referral:		
Name of Referral Source:		
Name & Title (Case Manager, Case Worker, School Counselor etc.):		
Address :		
Phone: **EXT:** **Cell:**	**Fax:**	**E-mail:**
Current IEP: Y N		

FUNDING
Highland Hospital will not be responsible for payment of medication costs, or any medical appointments/procedures that are not covered by Medicaid or Private Insurance.

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Responsible Party for Co-Pays and Unpaid Medical Bills:_____			
Medicaid ☐	**MCO:**	**Adoption Subsidy** ☐	**HMO:**
Medicaid Insurance #: **Social Security #:**		**Private Ins. Member #:**	
Private Ins. Company: **Phone:**		**Ins. Member's Name:** **Date of Birth:**	
Child's Full Name:		**Today's Date: / /**	
DOB: / /	☐ **Male** ☐ **Female**		
FUNDING/PLACING AGENCY INFORMATION			
Placing Agency/County (Agency FUNDING Placement):			
Address:		**Phone:** **Fax:**	
CSA Coordinator:		**E-Mail:**	
OTHER INVOLVEMENT *(Step-Parent, Foster Parent, GAL, CASA Worker, etc.)*			
Name/Relationship:		**Phone:**	
Address:		**Fax:**	
Name/Relationship:		**Phone:**	
Address:		**Fax:**	
MENTAL HEALTH INFORMATION			
Reason for Referral:			
Abuse History: **Physical** ☐ **Neglect** ☐ **Sexual** ☐ **Emotional** ☐			
Current Psychological and Psychiatric : Y N ***(Please Submit Copies)***			
EDUCATIONAL INFORMATION			
Current Grade:	**Local Education Agency (LEA):**	**IEP: Yes** ☐ **No** ☐ *****Please Submit Copy***	**Special Services:**
Current School:		**Address:**	
Phone:	**EXT:**	**Fax:**	
CHILD AND FAMILY INFORMATION			
Legal Involvement: ☐ **Yes** ☐ **No** **If "Yes", Explain:**		**Probation Officer:**	

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Current Legal Charges: **Adjudicated: Y N** **Pending Y N**	
Probation Officer Address:	**Phone:**
Is there a Protective Order in Place? Yes ☐ No ☐ **Is there any Restrictive Contact? Yes ☐ No ☐** **Explain:** **Explain:**	
Does Family have reliable transportation to attend Therapy/Treatment/Meetings? Yes ☐ No ☐	

HEALTH AND NUTRITION INFORMATION
Highland Hospital reserves the right to not admit a child who presents with a communicable disease at the time of admission, unless our Medical Director certifies that our facility is capable of providing care to the child without jeopardizing residents and staff. **Please advise the Admissions Director of any Communicable Disease -** **(i.e., Flu, Strep, MRSA, Lice, HIV, Hep. A, B, or C, etc.) your child may have prior to the time of Admission**
Does child wear orthodontic braces? **Date of last dental exam**: **Does child wear glasses?** **Date of last eye exam:**
Current Immunizations? Up to Date? Need?
Diagnosed Allergies -including drug/food allergy/intolerance: **Provide reports that support diagnosed allergy:**
Any noted nutritional problems? **Doctor Ordered Therapeutic Diet? Yes ☐ No ☐**

CURRENT PHYSICIAN INFORMATION		
Doctor Name:	**Last Appt:**	**Phone:**
Address:		**Fax:**
Dentist Name:	**Last Appt:**	**Phone:**
Address:		**Fax:**
Other Specialist:	**Last Appt:**	**Phone:**
Address:		**Fax:**

DEVELOPMENTAL HISTORY
Please indicate if there were any concerns with the following: **Born at _____ Months.** **Normal Delivery? Yes ☐ No ☐** **If no, explain_____**

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Complications at Birth? Yes ☐ No ☐ **If yes, explain**_____

Concerns with Gross Motor Skills? Yes ☐ No ☐ **If yes, explain**_____

Concerns with Fine Motor Skills? Yes ☐ No ☐ **If yes, explain**_____

Concerns with Speech Development? Yes ☐ No ☐ **If yes, explain**_____

What age was Child Toilet Trained? _____

OTHER INFORMATION

Likes: **Dislikes:**

Indicators of Success at Home/Other Placement:

History of Unsubstantiated Claims?

Current Mental Health Diagnosis:
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:
Other information:

Significant Behavior Information

(Please complete all boxes and explain behavior)

		Specific Behaviors	Frequency
Suicidal Ideation	Yes or No		
Homicidal Ideation	Yes or No		
Physical and Verbal Aggression	Yes or No		
Temper Outbursts/Destruction of Property	Yes or No		
Self-harming behaviors	Yes or No		

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Fire setting/animal cruelty	Yes or No		
Stealing/lying/running away	Yes or No		
Enuresis and Encopresis	Yes or No		
Anxious and Depressed Behavior	Yes or No		
Problems with sleep/nightmares/nighttime awakening	Yes or No		

School specific behaviors:	Hygiene:
Home specific behaviors:	Oppositional and Defiant Behaviors:
Ability to perform ADL's:	Other:

Explain from Above:

TREATMENT SERVICES AND PLACEMENT HISTORY FOR PAST YEAR			
Name of Service/Placement	**Type of Service/Placement**	**Dates of Service**	**Reason for Removal**

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		(*mm/dd/yy - mm/dd/yy)*	

MEDICATION RECONCILIATION FORM		
Current Medication Name	**Dosage**	**Schedule**
Medications Tried in the Past and Effects	**Dosage**	**Schedule**

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Information Provided By:_____

Relationship:_____ **Phone:**_____

Please fax the completed application and all required documents to the Admissions Department at 304.304-925-1524 or email to admissionsstaff@highlandhosp.com

***Further information needed prior to admission:

Client's MCM-1 with physician's signature and date.

Copy of psychological testing completed in the last 12 months.

Documentation indicating a child's failure in a less restrictive care setting in the past 6 months.

***Further information needed at admission:

Court Order proving that the patient is in custody of the State. (If patient has been removed from their home)

Copy of their social security card

Immunization Records

Copy of the birth certificate

Copy of Insurance or Medical Card

Any Applicable Court Orders

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Current copy of IEP/504 Plan

- **All Special Education Records (including testing)**

WVEIS Records

- **Attendance**
- **Behavior Documentation (From K to current grade)**

A list of scheduled appointments (Court, Dental Exam, Eye Exam, etc.)