

Consumer Name: _____



BayPointe Residential Referral Packet

If you are able, please e-mail the completed electronic referral packet to mbrotze@altapointe.org

If you are unable to save the file with the info you have entered,

Please print the packet and fax or mail with the required clinical documents to

(251) 662-8050

BayPointe Residential-5800 Southland Dr - Mobile 36693

For questions, please call (251) 662-8045

Consumer Name: _____



*The following items listed below are not required with the screening/application.
The following items ARE required for acceptance/prior to admission to the program:*

Requirements/Checklist for the referral process:

The follow documents are needed for placement consideration. Check off all included:

- Most recent psychiatric evaluation
- Most recent psychological evaluation
- Probation condition and name/contact information for P.O.
- Proof of custody/legal guardianship
- Current progress notes
- Discharge summaries from previous treatment
- Comprehensive family assessment or social history
- School status (ED, LD, Regular Classes)
- Funding source
- ISP (if applicable including permanency plan)

Once considered appropriate for admission, the following documents are required before admission:

- History / physical exam (within 1 month prior to admission)
- Current medication list
- Copy of birth certificate
- Copy of immunization record
- Social security card
- Insurance/Medicaid card

DHR Only

- 724
- Certificate of Need/Form 371
- copy of ISP (completed on admit)

For Special Education Students

- Current IEP
- Eligibility report and every item listed on the eligibility report
- Permission to place in special education
- Parent rights
- Consent to evaluate/reevaluate
- Most recent screening form
- Notice of proposed meeting forms for the IEP meeting and eligibility meeting
- Report Card/Transcripts

For General Education

- Report Card/transcripts

Hospital Use Only: _____ Medicaid admit review form

Consumer Name: _____



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Referral Application:

Application Date:

Person making referral:

Contact Name: _____ Agency: _____

Contact's Phone Number: _____ Contact's Fax Number: _____

Consumer Information:

Full Name: _____ Gender: M F

Address: _____

Race: _____ County of Origin: _____

DOB/Age: _____ SSN: _____

Legal Guardian: _____ Home: _____ Cell: _____

Relationship to Consumer: _____

Guardian's Address: _____

Child resides with (name): _____ Home: _____ Cell: _____

Insurance/policy number: _____

Income if Applicable: _____ Payee if Applicable: _____

Consumer Name: _____

Legal Status

- DHR Custody
- Dependent
- CHINS
- Delinquent
- Probation
 - (for: _____)

Adjudicated

- Pending court action for custody
- Multi-Needs
- Permanency Plan (DHR only)

Upcoming Court Date: _____

Clinical Information

Check all those that apply:

- Poor Self-Control
- Cruelty to Animals
- Aggressive Behaviors
- Hyperactivity
- Running Away
- Poor School Performance
- Truancy
- Defiance of Authority
- Manipulative Behavior
- Sexual Maladjustment
- Assaultive Behavior
- Child Abuse Victim
- Sexual Abuse Victim
- Sexual Perpetrator
- Dysfunctional Family Relationships
- Enuresis
- Encopresis
- Withdrawn/Regression/Confusion
- Moderate to Severe Depression
- Homicidal Ideation
- Suicidal Ideation
- Inadequate social skills/Poor Interpersonal Skills
- Drug Experimentation
- Irrational Fears
- Low frustration tolerance
- Inappropriate attention seeking behavior
- Inadequate problem solving skills
- In need of 24 hour protective oversight and supervision in daily living
- Impaired Reality Contact- e.g. hallucinations, delusions
- Disabling Somatic symptoms
- Other: _____
- Medication Non compliance
- Poor socialization skills

Explain checked items and include any recent precipitating events: _____

Consumer Name: _____

Sexual Behaviors: _____ Age of Onset: _____

Legal Consequences Associated with Behavior: _____

Aggressive Behaviors

Legal Consequences Associated with Behavior: _____

Describe aggression up to and including physical harm to others and frequency/duration: _____

Has consumer ever received treatment from another mental health organization? Yes No

Check types of services received:

- Outpatient counseling
- Outpatient Psychiatric
- Case Management
- In-home intervention
- Day Treatment
- Residential
- Inpatient
- Emergency afterhours
- Other

Age first began mental health treatment: _____

Dates	Type of Treatment	Agency-Address	Outcome/Diagnosis

Does the child exhibit developmental delay: Yes No

Explain: _____

Check those that apply:

- Mental Retardation
- Autism
- Other pervasive developmental disorder: _____
- Other developmental delay: _____

Who made diagnosis and date: _____

Consumer Name: _____

Family Information

Is the family aware of their child's problem? Yes No

Were family members informed/involved with this referral? Yes No

On a scale 1 (none at all) – 5 (extremely involved), to what degree do you think the family will participate regarding evaluation/treatment of their child? _____

Explain: _____

Where will child reside upon discharge from residential treatment?

- Family
- Foster care
- Group home
- Other: _____

List people living in client's current home:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

History of Abuse/Trauma

Hx of physical/sexual/emotional abuse (VICTIM) Yes No

Explain: _____

Hx of physical/sexual/emotional abuse (PERPETRATOR) Yes No

Explain: _____

Inappropriate Sexual Behavior Yes No

Explain _____

