

PRTF APPLICATION AND ADMISSION ASSESSMENT FORM



LMCH RUSTON

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DATE OF ADMISSION: _____

YOUTH INFORMATION

Child's Full Legal Name: _____ DOB: _____ Age: _____

Child's SSN: _____ JETS/TIPS # _____ Is child emancipated, married or had a child? Yes No

Healthy Louisiana Plan: Aetna Healthy Blue AmeriHealth Caritas Louisiana Healthcare Connections United Health Care

Medicaid #: _____ HLP Member #: _____

Any other Insurance available? _____

Allergies: _____

Sex: Male Female Height: _____ Weight: _____ Ethnicity/Race: _____ Eye Color: _____ Hair Color: _____

Child's Current Placement: Parents Group Home Foster Home Detention Other: _____

Child's Current Placement Address: _____

City: _____ Parish: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Referring Party: _____ Phone #: _____

DCFS/OJJ/DHH/PRI Name: _____ Email: _____

Work#: _____ Fax#: _____

Street: _____ City: _____ State: _____ Zip: _____

Name the Adult(s) that has Custody of the Child (*please provide custody order if necessary*):

Father: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

Mother: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

Other: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

DCFS/OJJ: _____ How long has child been in custody? _____

CURRENT BEHAVIORS

Why is admission into a Psychiatric Residential Program required at this time? _____

RISK ASSESSMENT

Is there risk or history of the child **attempting suicide**? Yes No. If "yes", explain with behaviors, dates of events, etc.: _____

Is there risk or history of the child **harming self/others**? Yes No. If "yes", explain with behaviors, dates of events, etc.: _____

Is there risk or history of the child **harming animals**? Yes No. If "yes", explain with behaviors, dates of events, etc.: _____

Is there risk or history of the child starting **fires**? Yes No. If "yes", explain with behaviors, dates of events, etc.: _____

Is there risk or history of the child **acting out sexually** with others? Yes No. If "yes", explain with behaviors, dates of events, etc.: _____

Is there risk or history of the child **running away**? Yes No. If "yes", explain with behaviors, dates of events, etc.: _____

Are there other **needs, activities or behaviors** that put this child at special risk? Yes No. If "yes", explain with behaviors, dates of events, etc.: _____

SUBSTANCE USE

Does this child have a history of substance use? Yes No. If "yes", describe in detail (what substance, frequency of use, amount, duration, last use, urinary drug screen results): _____

COORDINATED SYTEM OF CARE INVOLVEMENT

Has the child or family received case management or support services from CSOC, WAA, FSO, CFT, Magellan:

A Wrap Around Agency? Yes No If, "yes", which WAA? _____

If, "yes", the WAA worker's name: _____

A Family Support Organization? Yes No If, "yes", which FSO? _____

If, "yes", the FSO worker's name: _____

A Bayou Health Care Plan Case Manager? Yes No If, "yes", name of Case Manager: _____

A Child and Family Team? Yes No If, "yes", names of CFT participants: _____

Is child a previous resident of LMCH? Yes No If "Yes" what dates: _____

TARGETED TREATMENT GOALS

What are the goals for treatment which cannot be met in a less intensive level of care? _____

PREVIOUS TREATMENT

Has child received treatment from an Outpatient Therapist? Yes No

Name/Credentials: _____ Phone: _____

Start Date: _____ Last Appt: _____ Freq: Weekly Bi-Monthly Monthly Mode: Indiv Family Group

Provide History of Child's Previous Psychiatric Hospitalizations and Out-of-Home Placements:

PLEASE HAVE THESE DOCUMENTS AVAILABLE FROM PSYCHIATRIC HOSPITALS:

Name and Type of Facility	Admit Date	Discharge Date	Reason for Placement

Current Psychiatric Diagnosis -

Date of Diagnosis: _____ **Assessment Performed by:** DOCTOR'S NAME PLEASE: _____

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

GAF: Current _____ Highest in Last Year _____

HISTORY OF ABUSE, NEGLECT AND CRIME VICTIMIZATION

Please describe the child’s history of abuse, neglect and crime victimization:

Physical Abuse: _____

Sexual Abuse: _____

Mental/Emotional Abuse: _____

Neglect: _____

Exposure to Domestic Violence: _____

Exposure to Pornography: _____

Exposure to Adult Sexual Behavior: _____

Sexual Maladaptive Behaviors: _____

Victim of a Crime: _____

FAMILY INFORMATION

CURRENT FEMALE CARETAKER - PLEASE CIRCLE ONE (MOTHER, AUNT, GRANDMOTHER, ADOPTIVE MOTHER, OTHER)

Full Name: _____ Date of Birth: _____ SSN: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email: _____ Employer: _____ Job: _____

CURRENT MALE CARETAKER- PLEASE CIRCLE ONE (FATHER, UNCLE, GRANDFATHER, ADOPTIVE FATHER, OTHER)

Full Name: _____ Date of Birth: _____ SSN: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email: _____ Employer: _____ Job: _____

SIBLINGS

Sibling's Name	Sex	Age or DOB	Lives with

Have Parental Rights been Terminated for Biological Parents: No Yes _____

Anyone the child is **NOT** permitted to have contact? (legal documentation is required, ie. Court Order)

**** EDUCATIONAL INFORMATION - please complete this section thoroughly -**

Last School Attended: _____ Grade: _____

School Address: _____

City: _____ Parish: _____ State: _____ Zip: _____

List school behavior strengths/weaknesses: _____

_____ **FULL SCALE I.Q. -** _____

WHAT IS THE NAME AND ADDRESS USED FOR EDUCATIONAL ENROLLMENT?

GAURDIAN'S NAME: _____

GAURDIAN'S ADDRESS: _____

FUNCTIONAL STRENGTHS

For each area of life below, please indicate the child's strengths.

Social: _____

Family: _____

School: _____

Religious: _____

ADL'S: (Activities of Daily Living) _____

Other areas of life: _____

SUPPORT SYSTEMS

In each area below, list the individuals who are actively supportive of the child and/or family.

Family: _____

Social: _____

School: _____

Religious: _____

Treatment/Therapeutic: _____

Please describe the child's religious preference:

MEDICAL INFORMATION

LIST OF ALL DOCTORS:

Primary Care Physician: _____ Phone: _____

Address: _____ Date Last Seen: _____

Specialist: _____ Phone: _____

Address: _____ Date Last Seen: _____

Specialist: _____ Phone: _____

Address: _____ Date Last Seen: _____

Dentist: _____ Phone: _____

Address: _____ Date Last Seen: _____

Eye Doctor: _____ Phone: _____

Address: _____ Date Last Seen: _____

Please List ALL Current Medications:

Name of Medication and Dosage, Route, Frequency	Prescribed by:	Prescribed as Treatment for:

Is child compliant with current prescribed medications? Yes No

Are child's Immunizations Current? (Check one): Yes No *You MUST provide a COPY OF CHILD'S IMMUNIZATION RECORD.*

Have you EVER HAD, or do you now have any of the following? Check each item. If yes, specify and explain.

Anaphylaxis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aneurysm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arrhythmia (heart)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Back Pain/Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Infection (chronic)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Broken Bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ovarian Cysts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cystic Fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reflux/Esophagitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dermatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Renal Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures/Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shunts of any kind	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Problems/Chronic Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gallstones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Impairment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explanation of any "Yes" answers: _____

Surgeries: (Please list dates in box)

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Ovarian Cyst Removal	<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Splenectomy	<input type="checkbox"/> Kidney Surgery
<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Eye Surgery
<input type="checkbox"/> Gallbladder Removal	<input type="checkbox"/> Weight Loss Surgery	<input type="checkbox"/> Brain Surgery
<input type="checkbox"/> Organ Transplant	<input type="checkbox"/> Bone/Muscle Surgery	<input type="checkbox"/> OTHER:

Medical Hospitalizations (NON -PSYCHIATRIC):

Name of Facility	Admit Date	Discharge Date	Reason for Medical Hospitalization

Females Clients ONLY:

Onset of menses: _____ Difficult/Painful Periods Yes No # of Pregnancies: _____

Birth Control: Pill Depo Shot - date last given _____ Implant - Placed on: _____

STD's: (Please list treatment date in box if applicable)

<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> HPV/Genital Warts	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Herpes	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Trichomoniasis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Other

PRIVATELY PLACED YOUTH GUARDIAN CONTACT INFORMATION:

The guardian of the privately placed will be notified by *NURSING* to obtain consent prior to starting any new medications. In order for us to notify you and start the medication in a timely manner, two phone numbers are needed where the guardian can be reached with the best times to call. If these contact numbers change, please let *NURSING* know as soon as possible so that the care of your child will not be delayed. Thank you.

Primary Legal Guardian: _____

Primary Number: _____ Best time to call: _____

Secondary Number: _____ Best time to call: _____

STATEMENT OF APPLICATION FOR ADMISSION

Name of Person Completing this Application: _____

Relationship to Child: _____ Date: _____

I (we), the undersigned Parent(s) or Legal Guardian(s), do hereby apply to Louisiana United Methodist Children and Family Services, Inc. for Psychiatric Residential Treatment Facility (PRTF) services for the child named above for whom I (we) hold legal custody and/or placement authority. I(we) certify the information provided in this PRTF Application and Admission Assessment Form and the attached documents is true and accurate to the best of my (our) knowledge. I(we) agree to share additional information related to this application as it becomes available and/or is requested by Louisiana United Methodist Children and Family Services. I (we) also agree to fully cooperate with LUMCFS and to actively support the child’s plan of care to which we mutually agree.

Does any other adult have legal rights to this child? Yes No

If, “Yes”, please provide name and explain: _____

Signatures of Parent(s) or Legal Guardians(s) Requesting Child’s Admission

Parent Signature

Date

Printed Name

Relationship to Child

Parent Signature

Date

Printed Name

Relationship to Child

Legal Guardian Signature

Date

Printed Name

Relationship to Child

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