PRTF APPLICATION AND ADMISSION ASSESSMENT FORM

□ **LMCH RUSTON**
Phillip McMillan, Director of Admissions
904 Deville Lane, Ruston, LA 71270
Phone: 318.255.5020 Fax: 318.734.9060

□ **MCH of SWLA**
Steven Franks, Program Director
3029 N. Beglis Parkway, Sulfur, LA 70663
Phone: 337.527.5056 Fax: 337.527-5367

□ **MCH of SELA**
Marlin Giacona, Program Director
49242 HWY 445, Loranger, LA 70446
Phone: 985.606.9900 Fax: 985.606.9970

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 Treatment 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?

GUARDIAN'S NAME: _____

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

Explanation of any "Yes" answers: _____

_____

_____

Surgeries: (Please list dates in box)

▫ Appendectomy	▫ Ovarian Cyst Removal	▫ Heart Surgery
▫ Adenoidectomy	▫ Splenectomy	▫ Kidney Surgery
▫ Ear Tubes	▫ Tonsillectomy	▫ Eye Surgery
▫ Gallbladder Removal	▫ Weight Loss Surgery	▫ Brain Surgery
▫ Organ Transplant	▫ Bone/Muscle Surgery	▫ 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)

▫ HIV/Aids	▫ HPV/Genital Warts	▫ Chlamydia
▫ Hepatitis	▫ Herpes	▫ Syphilis
▫ Trichomoniasis	▫ Gonorrhea	▫ Other

PRIVATELY PLACED YOUTH'S GUARDIAN CONTACT INFORMATION:

The guardian of privately placed youth 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 required where the guardian can be reached with the best times to call. If these contact numbers change, you MUST 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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