

Carrie's House
618 W. 38th Street Norfolk, VA 23508
(757)623-6418 (757) 623-6417 (fax)

RESIDENT SCREENING FORM

1. Person being referred: _____
 2. DOB: _____ SS#: _____
 3. Agency Worker: _____
 4. Agency Name: _____
Address _____ City: _____ State: _____ Zip: _____
 5. Type of placement:
 Therapeutic Care Crisis Stabilization Transitional Services
 Respite
 6. Type of Referral: Court Social Services Area Mental Health
 7. Major offenses precipitating placement: _____
Ex. Theft, Truancy, Vandalism, Assault, etc.
 8. Usual living arrangement: _____
Ex. Father, Mother, Both, Other
 9. Who has custody? _____
Ex. County, Court, Parental Custody
 10. Name and address of person have custody: _____
-

Reason for Referral for Placement: (Number one or more by priority)

- Needs controlled setting and supervision
- Needs cooling off period away from home
- Chemical Use Issues
- Sexuality Issues: Victim Perpetrator
- Mental Health Issues
- Other: _____

Projected Discharge Placement:

- 1. Parent Home: _____
- 2. Independent Living
- 3. Other

Exclusion

- Resident has tuberculosis in a communicable form.
- Resident is in need of extensive nursing care procedures.
- Resident requires intrusive therapies, seclusions, or mechanical restraints.
- Resident has a history (within 2 years) of creating unsafe conditions such as fire abuse.
- Resident's needs are unavailable by Carrie's House.
- Resident requires a wheelchair for mobility.
- Resident does not have a primary diagnosis of mental illness.

Action Taken:

- Accept _____
Denial _____

Admission Assessment Form

Client Name: _____ Date: _____

Address: _____ Tel #: _____
_____ Referrer: _____

Date of Birth: _____ Place of birth: _____
SSN: _____ Religion: _____

What program are you being referred to?

ETHNIC ORIGIN

0-White		5-Pakistani	
1-Caribbean		6-Bangladeshi	
2-African American		7-Asian Non-Pacific	
3-Asian Pacific		8-Any Other Group	
4-Indian			

Presenting Problems (s): (Why do you think that you are being referred/what do you hope to gain?)

Needs/Strengths:

Mood/Cognitive Functioning/Thought Disorder/Behaviors/Phobias:

Diagnosis:

Mental/Emotional/Psychological/Educational Needs:

Risk: (To self/others/neglect/vulnerability/aggressive behavior/impulsive behavior):

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Medication/Drug/Alcohol Use: (Prescribed Non-Prescribed/Type/Quantity/ Pattern of use/Length of Use:

Health History: (Sleep/Appetite/General Health/Illness/Disabilities/Agencies Involved/Self-Care/Sexual Health/Health Promotion Needs):

Social Health: (Personal & Family History/Current Situation- i.e. Housing/Employment/Financial/Dependants/ Ethnic & Spiritual Needs):

Evaluations Presented:

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Summary/Plans: (Including Identified Need, Planned Intervention(s) :

Disposition: (Referred to):

Agency Signature: _____ Date: _____

Staff Signature: _____ Date: _____

RELEASE OF INFORMATION

Agency requesting/information:
Carrie's House
618 W. 38th Street
Norfolk, VA 23508
Telephone: (757)623-6418

Agency releasing information:

We, I, _____, self, parent/legal guardian, give permission for Carrie's House to receive/release confidential information from/to the above named agency. I understand that this consent will expire on _____, and may be revoked at any time.

Date Initials

Specific Information Requested:

- | | |
|--|--|
| _____ Medical History | _____ Progress Reports |
| _____ Psychological Testing reports
Including IQ scores | _____ Correspondence with other
agencies |
| _____ Course of treatment summary | _____ Social History |
| _____ Substance Abuse History,
Treatment progress | _____ Information related to court
services |
| _____ School records, including
attendance, grades, behavior problems | _____ Psychiatric History |
| _____ Client's response to treatment | _____ Diagnostic Information |
| _____ Treatment recommendations | _____ FAPT reports |
| _____ Other: _____ | |

Purpose or Need for Release of information:

_____/_____
Resident's Signature Date of birth Date

Parent/Legal Guardian Signature Date

Staff Witness Signature Date

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Placement Authorization

This agreement certifies that _____ has been referred to Carrie's House in need of Group Home services. Carrie's House agrees to provide intensive individualized treatment services beginning on _____. We the placing agency, assume all financial responsibility for this placement.

The parents/guardians hereby authorize Carrie's House, to obtain routine, emergency or other medical, educational, psychiatric or dental care, and administer any prescription, non-prescription/over-the-counter medication as needed. The Group Home named above are also authorized to take this client out of the city for purposes of short business or pleasure (trips), but may not travel out of the state without the specific consent of the legal guardian and the Parent/guardian. Carrie's House is authorized to enroll the client in public school/supported employment (if need arises) and act as the paternal figure for school related affairs.

The legal guardian will be informed of visitation policies at admission. In the event an emergency should arise, Carrie's House will contact the legal guardian within 24 hours.

The below listed signatures certify that they have the legal authority to place and accept placement for this client. _____ has been placed in the Group Home of Carrie's House, if this resident becomes absent from this facility, the legal guardian will be contacted within 24 hours. I understand that by executing this agreement, I am obligating the referring agency to pay the daily per diem charge of \$300.00 established by Carrie's House.

Legal Representative _____ Date _____

Parent/Guardian _____ Date _____

Carrie's House Representative Date _____

Medical Assessment

Client Name: _____ Date of Birth: _____

Medicaid Number: _____ Insurance Number: _____

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Dentist's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Notification: _____ Phone No: _____

Address:

City: _____ State: _____ Zip Code: _____

Prescribed Medications (dosage and frequency):

Non prescription Medications (consistent usage within the last year):

Medications and Food Allergies:

Significant Medical Problems:

Medical Assessment
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History of Substance Abuse:

Significant Communication Problems:

Any advance medical directives:

AUTHORIZATION FOR EMERGENCY MEDICAL AND DENTAL CARE

I. The staff of Carrie's House is authorized to obtain medical and dental treatment as per the Emergency Medical Guidelines of Campbell's House, Inc.

II. I understand that I will be notified immediately should an emergency occur.

Parent/ Guardian

Date

Witness

Date