

# Shodair Children's Hospital

P.O. Box 5539 Helena, MT 59604 ☎ Phone: 800-447-6614 or 406-444-7500 ☎ Fax: 406-444-1039

Hello ~

Enclosed is our residential application. Please feel free to make a copy of the application to keep for your files. A copy of the application can also be e-mailed or faxed to you, if needed.

This application needs to be filled out **completely** and **legibly**, with as much **detail** as possible. The application is usually completed by a parent or the legal guardian. Once completed you may submit this application over the WEB or fax or mail back to us. We are not able to accept applications by e-mail. Please also gather any supporting documentation to accompany the application, which will give additional information about the child and why the child needs residential treatment. A "Release of Information" form has been included in this application to aide in this process of obtaining additional records from treating providers. Our mailing address is: Shodair Children's Hospital, PO Box 5539, Helena, MT, 59604. The Admission Department's fax number is 406-444-1039.

Please **describe** behaviors, etc. on the application. For example: instead of saying "aggressive behaviors" describe what the behaviors are (hitting, biting, kicking, etc.), how frequently they occur, the last time it happened, how long it lasts, who/what the behaviors are aimed at (peers, parents, siblings, teachers, toys, furniture, etc.), known triggers, etc. Our having detailed information from the beginning speeds up the evaluation process. Once we receive this information we will evaluate it to see if the child is appropriate for our services and then will get back to you with an answer.

If you have any questions or if we can be of further assistance, please call 1-800-447-6614 and ask for the Intake Department.

**SHODAIR RTC ADMISSION ASSESSMENT**

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Age: \_\_\_\_\_yo  Male  Female

Patient SS#: \_\_\_\_\_ Is youth emancipated, married or had a child? Yes No

Insurance: Medicaid CHIPS SSI None Private Insurance: \_\_\_\_\_  
(photocopy insurance card or list the policy name, subscriber, policy #, phone #)

Patient Living Arrangement:  Parents  Group Home  Foster Home  JDC  Shelter  Other: \_\_\_\_\_

Name of Legal Guardian: \_\_\_\_\_ Hm#) \_\_\_\_\_ Wk#) \_\_\_\_\_ Cell#) \_\_\_\_\_

Admission is sought for the following reasons: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Assaultive behavior? Yes No Suicidal behavior? Yes No Is patient an eminent danger to self or others? Yes No

Previous hospitalizations (Where/When): \_\_\_\_\_

Outpatient therapy?  **Yes**  **No** Therapist Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Start date: \_\_\_\_\_ Frequency: Weekly Bi-Monthly Monthly As Needed Modality: Ind. Family

Mental Health Case Manager?  **Yes**  **No** Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Current Meds/Doses: \_\_\_\_\_

Meds prescribed by: \_\_\_\_\_ Phone # \_\_\_\_\_

General Practitioner \_\_\_\_\_ Phone # \_\_\_\_\_

Victim of Sexual Abuse?  **Yes**  **No** History of sexual actions with minors?  **Yes**  **No** \_\_\_\_\_

Need for sex offender treatment?  **Yes**  **No** Previous sex offender treatment?  **Yes**  **No** \_\_\_\_\_

Physical health needs?  **Yes**  **No** Identify: \_\_\_\_\_

Cognitive or developmental delays?  **Yes**  **No** Identify: \_\_\_\_\_

Legal History? \_\_\_\_\_ Name of Probation Officer: \_\_\_\_\_

Drug or Alcohol Use? \_\_\_\_\_ Any Tx. Center? \_\_\_\_\_

Psychiatric Diagnoses Identified: \_\_\_\_\_

Shodair Child and Adolescent Psychiatric Program

**RTC- Psychosocial and Family Assessment**

Medical  
**Records  
Label**

Admit Date \_\_\_\_\_

What is the legal status of the patient's admission to Shodair? **Voluntary** **Court Order**

**IDENTIFYING INFORMATION**

Ethnicity \_\_\_\_\_ Tribe \_\_\_\_\_ Birthplace \_\_\_\_\_

Child's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Child's Phone number: \_\_\_\_\_

Guardian's Address (if not parent & if different than child's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Guardian's Phone # \_\_\_\_\_

**FAMILY HISTORY**

- 1) How long were the biological parents together? \_\_\_\_\_  
 Are the parents currently: TOGETHER SEPARATED DIVORCED  
 If separated/divorced, when did the separation/divorce take place? \_\_\_\_\_
- 2) Have the parents had additional marriages? **YES NO**  
 If "YES", please identify date(s) of marriage(s) and divorce(s): \_\_\_\_\_
- 3) Does the child have contact with both biological parents?: **YES NO, why?** \_\_\_\_\_
- 4) Is there any information that cannot be disclosed to the patient at this time? **NO YES (explain)**

**Is it okay to contact non-custodial parent? Yes No**  
**If no, explain** \_\_\_\_\_

Biological parents married when child was born? **YES NO**  
If not together, date of parental separation (divorce, breakup, etc.) \_\_\_\_\_

**Name of Biological Father:** \_\_\_\_\_ SS# \_\_\_\_\_

- 1. Parental rights terminated? **NO YES** \_\_\_\_\_
- 2. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_
- 3. Phone: home# \_\_\_\_\_ cell# \_\_\_\_\_ wk# \_\_\_\_\_
- 4. Employer \_\_\_\_\_ Occupation \_\_\_\_\_
- 5. Level of Education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other: \_\_\_\_\_
- 6. Mental illness, father or family? **NO YES:** \_\_\_\_\_
- 7. Substance abuse, father or family ? **NO YES:** \_\_\_\_\_

- 8. Any Learning disabilities in family? **NO YES:** \_\_\_\_\_
- 9. Military service history: **NO YES:** \_\_\_\_\_
- 10. Any previous marriages? **NO YES:** \_\_\_\_\_ # of kids from previous marriage: \_\_\_\_\_
- 11. How did parent get along with own parents? \_\_\_\_\_

**Name of Biological Mother:** \_\_\_\_\_ SS# \_\_\_\_\_

- 1. Parental rights terminated? **NO YES** \_\_\_\_\_
  - 2. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_
  - 3. Phone: home# \_\_\_\_\_ cell# \_\_\_\_\_ wk# \_\_\_\_\_
  - 4. Employer \_\_\_\_\_ Occupation \_\_\_\_\_
  - 5. Level of Education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other: \_\_\_\_\_
  - 6. Mental illness, mother or family? **NO YES:** \_\_\_\_\_
- 
- 7. Substance abuse, mother or family ? **NO YES:** \_\_\_\_\_
- 
- 8. Any Learning disabilities in family? **NO YES:** \_\_\_\_\_
  - 9. Military service history: **NO YES:** \_\_\_\_\_
  - 10. Any previous marriages? **NO YES:** \_\_\_\_\_ # of kids from previous marriage: \_\_\_\_\_
  - 11. How did parent get along with own parents? \_\_\_\_\_

**Other Adult involved with patient:** \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to child: **Adoptive Parent Step Parent Legal Guardian Foster Parent Or:** \_\_\_\_\_

- 1. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_
  - 2. Phone: home# \_\_\_\_\_ cell# \_\_\_\_\_ wk# \_\_\_\_\_
  - 3. Employer \_\_\_\_\_ Occupation \_\_\_\_\_
  - 4. Level of Education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other: \_\_\_\_\_
  - 5. Mental illness, parent or family? **NO YES:** \_\_\_\_\_
- 
- 6. Substance abuse, parent or family? **NO YES:** \_\_\_\_\_

**Other adult involved with patient:** \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to child: **Adoptive Parent Step Parent Legal Guardian Foster Parent Or:** \_\_\_\_\_

- 1. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZipCode \_\_\_\_\_  
home# \_\_\_\_\_ cell# \_\_\_\_\_
- 2. Employer \_\_\_\_\_ Occupation \_\_\_\_\_ wk# \_\_\_\_\_
- 3. Level of Education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other: \_\_\_\_\_
- 4. Mental illness, parent or family? **NO YES:** \_\_\_\_\_
- 5. Substance abuse, parent or family? **NO YES:** \_\_\_\_\_

Is there a Guardian Ad Litem involved? Name \_\_\_\_\_ phone# \_\_\_\_\_

Is there any information that cannot be disclosed to the patient at this time? **NO YES:** \_\_\_\_\_

***FAMILY CONSTELLATION:***

Siblings:

(**H**-Half, **F**-Full, **S**-Step, **A**-Adoptive)

	<u>Name</u>	<u>Gender</u>	<u>Age</u>	<u>Relationship</u>	<u>Residence</u>
1)	_____	<b>M F</b>	_____	<b>H F S A</b>	_____
2)	_____	<b>M F</b>	_____	<b>H F S A</b>	_____
3)	_____	<b>M F</b>	_____	<b>H F S A</b>	_____
4)	_____	<b>M F</b>	_____	<b>H F S A</b>	_____

Relationship with siblings: \_\_\_\_\_

How long has the patient lived in the current residency? \_\_\_\_\_

Where else has the patient lived in the past five years? \_\_\_\_\_

Who is currently living in the home? \_\_\_\_\_

Who was responsible for discipline and what was the discipline? \_\_\_\_\_

**CURRENT LEVEL OF FUNCTIONING**

**Behavioral Profile**

Describe any suicidal or self-harming behavior: \_\_\_\_\_

Describe any homicidal or assaultive behavior: \_\_\_\_\_

Describe any depression (onset, duration, provocation): \_\_\_\_\_

Describe any psychotic behavior (onset, duration, triggers): \_\_\_\_\_

Describe the child's usual mood: \_\_\_\_\_

Describe any mood swings: \_\_\_\_\_

Describe any significant losses: \_\_\_\_\_

Describe any sleep problems (onset, provocation, frequency): \_\_\_\_\_

Describe any appetite problems (onset, provocation, frequency): \_\_\_\_\_

Describe any pyromania (fire setting): \_\_\_\_\_

Describe any theft: \_\_\_\_\_

Describe any cruelty to animals: \_\_\_\_\_

Describe any verbal abuse/swearing: \_\_\_\_\_

Describe any history of temper tantrums (recent?, if previous, when they stopped): \_\_\_\_\_

Describe any destruction of property/vandalism: \_\_\_\_\_

Describe any enuresis, encopresis, or urinating in inappropriate places: \_\_\_\_\_

Describe extent of any alcohol use or drug use or smoking: \_\_\_\_\_

Describe any lying: \_\_\_\_\_

Describe any running away: \_\_\_\_\_

Describe any poor hygiene: \_\_\_\_\_

Describe any impulsive behavior (doing without thinking): \_\_\_\_\_

Describe any problems with memory or concentration (onset): \_\_\_\_\_

Describe any risky behavior? \_\_\_\_\_

Describe any problems playing with others (is child invited to others' houses for day, overnight): \_\_\_\_\_

Describe any problems with peer group (what is typical relationship like with peers?): \_\_\_\_\_

Describe any inappropriate sexual behavior (public masturbation, fondling, exposing self, etc.): \_\_\_\_\_

How has the family reacted to the patient's problems? \_\_\_\_\_

## PAST TREATMENT HISTORY

Where has the patient received therapeutic services in the past? (Most recent first, **I**-Inpatient, **O**-Outpatient)

	<u>Name of Agency/Therapist</u>	<u>Dates</u>	<u>Level</u>	<u>Primary Referring Problem(s)</u>
1)	_____	_____	<b>I O</b>	_____
2)	_____	_____	<b>I O</b>	_____
3)	_____	_____	<b>I O</b>	_____
4)	_____	_____	<b>I O</b>	_____
5)	_____	_____	<b>I O</b>	_____

**Other services received:** (and reasons previous services were stopped)

Case Management: \_\_\_\_\_

In Home Family Based Services/Dates: \_\_\_\_\_

Parenting Classes/Dates: \_\_\_\_\_

Neurological Evaluations/Dates: \_\_\_\_\_

Any Prior Psychological Testing?      **NO**      **YES**

When: \_\_\_\_\_, Where: \_\_\_\_\_ By whom: \_\_\_\_\_

Why: \_\_\_\_\_ I.Q. \_\_\_\_\_

**Previous DSM IV Diagnosis' indicated:**

Is this diagnosis from:    **Shodair**      **Other:** \_\_\_\_\_      Date: \_\_\_\_\_

AXIS I: \_\_\_\_\_

AXIS II: \_\_\_\_\_

AXIS III: \_\_\_\_\_

AXIS IV: \_\_\_\_\_

AXIS V:      GAF= \_\_\_\_\_

## CHILD'S DEVELOPMENTAL HISTORY

Child's Current Height \_\_\_\_\_ Child's Current Weight \_\_\_\_\_

Problems during pregnancy/birth? **NO YES:** \_\_\_\_\_

Any history of prenatal substance exposure?:    **NO YES:** \_\_\_\_\_

Any history of postpartum depression?    **NO YES:** \_\_\_\_\_

When did the child start walking? \_\_\_\_\_ talking? \_\_\_\_\_ toilet trained? \_\_\_\_\_

Any periods where child regressed?    **NO YES:** \_\_\_\_\_

Any negative responses to separation from parents, feeding schedules, change? **NO YES** \_\_\_\_\_

Medical/Accidents? **NONE PROB:** \_\_\_\_\_

Any behavior or temperament problems? **NO YES:** \_\_\_\_\_

**NEGLECT AND ABUSE HISTORY**

Any history of physical abuse? **NO YES?** \_\_\_\_\_

Any history of sexual abuse (including rape)? **NO YES?** \_\_\_\_\_

Any history of neglect? **NO YES?** \_\_\_\_\_

Any exposure to violence (movies or domestic violence)? **NO YES:** \_\_\_\_\_

Has Social Services ever investigated the family or patient? **NO YES**

<u>When?</u>	<u>Why?</u>	<u>Findings/Result of Investigation</u>
1) _____	_____	_____
2) _____	_____	_____

**EDUCATIONAL HISTORY**

Current School? \_\_\_\_\_ Current Grade? \_\_\_\_\_

Name of primary school contact: \_\_\_\_\_

Special education services or 504 plan? **NO YES:** \_\_\_\_\_

Learning disabilities? **NO YES:** \_\_\_\_\_

Peer/Teacher Relations? \_\_\_\_\_

Preferred Learning Method: **Visual Auditory Tactile**

Recent school performance (grades, behavior): \_\_\_\_\_

Number of days of school missed in past year? **0-5 6-10 11-15 >15**

**ENVIRONMENTAL AND CULTURAL FACTORS**

**Cultural and Spiritual Needs/Issues**

Spiritual affiliation? \_\_\_\_\_

Active in cultural or spiritual activities? **NO YES:** \_\_\_\_\_

Cultural/environmental factors impeding accessibility to treatment? **NO YES:** \_\_\_\_\_

**Leisure/Recreation Interests**

What are the patient's interests/hobbies?: \_\_\_\_\_

Hours of TV, video games, computer per week?      <10                      11-24                      >25

**Environmental Needs**

Patient has stable housing?      **YES**    **NO:** \_\_\_\_\_

Neighborhood safe?      **YES**    **NO:** \_\_\_\_\_

**Discharge Placement after Residential Treatment:** \_\_\_\_\_

**Available Community Resources**

What support systems or community resources does the family have access to?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Church          | <input type="checkbox"/> Recreation Center | <input type="checkbox"/> Mental Health Services        |
| <input type="checkbox"/> D.P.H.H.S       | <input type="checkbox"/> Probation         | <input type="checkbox"/> Neighborhood Community Center |
| <input type="checkbox"/> Extended Family | <input type="checkbox"/> Advocacy Group    | <input type="checkbox"/> Neighbors                     |
| <input type="checkbox"/> Other: _____    | <input type="checkbox"/> Other: _____      | <input type="checkbox"/> Other: _____                  |

\_\_\_\_\_  
**Signature of Person completing this form**

\_\_\_\_\_  
**Date**

# ADDRESS WORKSHEET

## Legal Guardian

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## Case Manager

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Direct Phone Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## Therapist

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Direct Phone Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## Probation Officer

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Direct Phone Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## Medication Management

Name: \_\_\_\_\_

Agency or Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Direct Phone Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## Other (ie: DFS worker, CASA worker, Guardian ad Litem, etc.)

Name/Relationship: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Direct Phone Number: \_\_\_\_\_

Cell Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

# Montana Medicaid and Mental Health Services Plan

Acute Inpatient Hospitalization/Residential Treatment Care

For Individuals under 21

## CERTIFICATE OF NEED

Check One: Acute inpatient: (Medicaid Only)

Residential Treatment Center:

Recipient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

SSN: \_\_\_\_\_

Medicaid/MHSP ID Number: \_\_\_\_\_

Admitting Facility: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Proposed Admission Date: \_\_\_\_\_

Expected Discharge Date: \_\_\_\_\_

### At the time of admission the interdisciplinary team certifies the following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient; (include documentation)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; (include documentation)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. (include documentation)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print/Type Name of Physician Team Member

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Physician Team Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print/Type Name of Mental Health Professional

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature of Mental Health Professional

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print/Type Name of Case Manager (Required for RTC only)

\_\_\_\_\_  
Mental Health Center

\_\_\_\_\_  
Signature of Case Manager

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION  
SHODAIR HOSPITAL  
2755 COLONIAL DRIVE  
P.O. BOX 5539 HELENA, MT 59604  
(406) 444-7500 OR 1-800-447-6614

NAME OF PATIENT: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ MEDICAL RECORD NUMBER: \_\_\_\_\_

I hereby authorize Shodair Hospital to:  Request information from:  
 Disclose information to:

Name/Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

This information will be used to facilitate evaluation, treatment, and aftercare services for the patient and the family.

**INFORMATION REQUESTED/TO BE DISCLOSED: (CHECK ALL THAT APPLY)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> H&P/Medical                   | <input type="checkbox"/> Educational     | <input type="checkbox"/> Psychiatric/Psychological |
| <input type="checkbox"/> Office Notes                  | <input type="checkbox"/> Consultations   | <input type="checkbox"/> Chemical Abuse/Dependence |
| <input type="checkbox"/> Lab/Special Reports           | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Discharge Summary         |
| <input type="checkbox"/> Immunization Record           | <input type="checkbox"/> Social History  | <input type="checkbox"/> Legal                     |
| <input type="checkbox"/> Other (Please specify): _____ |  |  |

This authorization will remain valid for a period of 30 (thirty) months from date of signature unless revoked before that time as described below.

I understand that this authorization for release of information may be revoked at any time in writing unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization. Leaving treatment at Shodair against medical advice does not, in and of itself, constitute a revocation of this authorization for release of information. Shodair Hospital may not condition treatment or payment on whether an individual signs this authorization.

The potential exists for information disclosed pursuant to this authorization to be re-disclosed by the recipient and no longer be protected by federal law. The undersigned person(s) agree to indemnify and hold harmless Shodair Hospital and its employees from all claims or liability that may arise as a result of Shodair's compliance with this authorization.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian (Circle Applicable Status)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Patient

**PROHIBITION ON REDISCLOSURE:** This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 C.F.R.) Part 2 prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal Regulations state that any person who violates any provision of this law shall be fined not more than \$500 in the case of the first offense and not more than \$5,000 in the case of each subsequent offense.

\*\*\*\*\*

For Shodair Use Only: Date Records Requested \_\_\_\_\_ Date Records Received \_\_\_\_\_  
ROI.1/W.FILE/RELEASES FD: 6/22/00 REV: 4/03 REV: 5/06