ORCHARD PLACE CAMPUS ACCESS FORM

Please complete the following information to the best of your ability. This information is critical to the treatment that your child and family will receive. Full and accurate information is necessary. Please return this form to the Orchard Place admissions personnel at
925 SW Porter Ave, Des Moines, IA 50315 or Fax to 515- 287-9695

Date Request Made:

Person Filling Out Form and Relationship to Child:

CHILD'S DEMOGRAPHIC INFORMATION

Full Name (First, Middle, Last):

Preferred Name/Nickname:

Gender: ◯ Female ◯ Male ◯ Other SSN Date of Birth Age

Current Street Address

City State Zip Code County

City/State Born in: Religious Preference

SECTION 1: REFERRAL INFORMATION/PRESENTING CONCERNS

Who is recommending Orchard Place Campus for your child?

Reason for Referral: Please list the biggest problems your child is currently experiencing. Include behaviors, age of onset and examples.

SECTION 2: SERVICES PROVIDERS/SUPPORTS

Check all services child is currently receiving or has received in the past year.

- ☐ Attorney
- ☐ BHIS
- ☐ Court Based Intervention
- ☐ Day Treatment/Partial Hospitalization
- ☐ DHS Worker
- ☐ Detention
- ☐ Early Service Project
- ☐ Foster Care
- ☐ Integrated Health Program
- ☐ Guardian Ad Litem Inpatient
- ☐ Hospitalization
- ☐ IQ Testing
- ☐ Juvenile Court Officer (JCO) or Probation Officer
- ☐ Juvenile Court School Liaison
- ☐ Medication Management
- ☐ PMIC
- ☐ Primary Care Physician (PCP)
- ☐ Psychiatrist
- ☐ Psychological Testing
- ☐ Residential Treatment
- ☐ Shelter
- ☐ Substance Abuse Program
- ☐ Tracker
- ☐ Therapy
- ☐ Other

Describe Other Services:

SECTION 3: FAMILY INFORMATION

Legal Custodian of Child:

Who Does Child Normally Live with:

Where is Child Living Now?

If Out of Home, List Date Placed at this Location Last Date Child Lived at Home:

For adults the child is current living with please provide the following information:

Adult Name Relationship to Client:

Work Phone Home Phone Cell

E-mail Preferred Method of contact: ☐ Home ☐ Cell ☐ Work ☐ E-mail

Adult Name Relationship to Client:

Work Phone Home Phone Cell

E-mail Preferred Method of contact: ☐ Home ☐ Cell ☐ Work ☐ E-mail

If child is not living with biological parent(s), please provide in the following information on biological parent(s).

Adult Name Relationship to Client:

Work Phone Home Phone Cell

E-mail Preferred Method of contact: ☐ Home ☐ Cell ☐ Work ☐ E-mail

Adult Name Relationship to Client:

Work Phone Home Phone Cell

E-mail Preferred Method of contact: ☐ Home ☐ Cell ☐ Work ☐ E-mail

Is your child adopted? ◯ Yes ◯ No If Yes, at what age?

List important information about the birth family:

Who is the child close to in the immediate and in the extended family?

Family Stressors and Family Mental Health History: (select all the apply)

- ☐ Abandonment
- ☐ Abuse
- ☐ Child abuse investigation current or previous
- ☐ Child custody/visitation dispute
- ☐ Citizenship
- ☐ Court involvement
- ☐ DHS involvement
- ☐ Death
- ☐ Disability
- ☐ Domestic violence
- ☐ Educational
- ☐ Employment
- ☐ Financial
- ☐ Illness
- ☐ Incarceration
- ☐ Mental health disorder
- ☐ Neighborhood
- ☐ Transportation
- ☐ Numerous moves
- ☐ Physical Illness
- ☐ Separation/divorce
- ☐ Sibling rivalry/conflict
- ☐ Substance abuse
- ☐ Suicides attempts in the family
- ☐ Suicides completions in the family
- ☐ Transportation
- ☐ Other (explain below)

Describe Other Stressor or Mental Health History:

For each item identified above, please describe:
If abuse, abuse investigation, suicide attempts or completions or family mental health issues, please indicate who and their relationship to the child.

SECTION 4: DEVELOPMENTAL HISTORY

Substance Used and/or Medications Prescribed During the Pregnancy: ○ Yes ○ No ○ Unknown

If yes: (select all that apply) ☐ Alcohol ☐ Cigarettes ☐ Prescription Drugs ☐ Street Drugs

Description of Substance Type and Frequency of Use:

SECTION 5: MEDICATIONS, DIAGNOSIS AND USE OF / HISTORY OF RESTRAINT OR SECLUSION

Please list your child's **current** psychiatric diagnosis:

Please list your child's previous psychiatric diagnosis:

Is child **currently** taking psychiatric medications? ◯ Yes ◯ No List current psychiatric medication and response to the medication:

Has your child taken psychiatric medications previously? ◯ Yes ◯ No

If yes, list previous psychiatric medication, response to the medication and reason for discontinuing:

Has your child ever been restrained in a hospital, in a crisis stabilization unit, school at home or other setting ◯ Yes ◯ No

If yes, Describe

Are you aware of any medical conditions or any physical disabilities that may cause problems during a physical restraint?

SECTION 6: LIFE SKILLS AND BEHAVIORAL INFORMATION

Check all daily living activities your child can perform independently.

- ☐ Bathing
- ☐ Brushing Teeth
- ☐ Cleaning
- ☐ Cooking Simple Meals
- ☐ Doing Laundry
- ☐ Dressing Approriately
- ☐ Driving
- ☐ Grooming self
- ☐ Managing Medications
- ☐ Using the phone
- ☐ Waking up on Own
- ☐ Washing Hair
- ☐ Other

Please list any concerns you have about your child's life skills or skills your child needs assistance with:

Any concerns with wetting or soiling self either during the day or at night? ◯ Yes ◯ No If yes, describe below

Behavioral History and Concerns: (Select all that apply)

- ☐ Addictive behaviors
- ☐ Aggression towards others
- ☐ Aggression with property
- ☐ Attempts to kill self
- ☐ Attempts to kill others
- ☐ Bouts of severe anxiety/panics
- ☐ Confused/inflexible thinking
- ☐ Confusion of fantasy and reality
- ☐ Cussing
- ☐ Depressive statements
- ☐ Disorientated
- ☐ Easily distracted
- ☐ Easily frustrated
- ☐ Fire-setting
- ☐ Hearing voices or seeing visions
- ☐ Hurts animals or others
- ☐ Hyperactive
- ☐ Impulsive
- ☐ Inability to plan, organize, or sequence
- ☐ Inattentive
- ☐ Irritability/temper
- ☐ Language/speech problems
- ☐ Lying(other than minor ones)
- ☐ Outbursts
- ☐ Paranoid or unusual fears
- ☐ Picking at sores
- ☐ Plays with Objects unusually
- ☐ Problem with authority
- ☐ Pulling out eyelashes
- ☐ Refuses to follow directions
- ☐ Repetitive behaviors
- ☐ Rocking/banging
- ☐ Running away
- ☐ Self-injury
- ☐ Short or long term memory problems
- ☐ Stealing
- ☐ Talks to self
- ☐ Throwing things
- ☐ Unusual thinking, eg. odd or off-the-wall ideas
- ☐ Yelling
- ☐ Other (explain below)

Description of Behavioral History and Concerns:

If your child has a history of running away: How many times have they run away?

Describe what triggers the child to run away? How long are they gone?

Any history that would indicate child needs a single room such as: sexual behavior, aggression, socialization issues? (please note children needing single rooms may have to wait longer to be admitted)

Other concerns or comments

SECTION 7: EDUCATIONAL HISTORY

Name of Current or Most Recent School:

Address: Grade

Current Individualized Education Plan (IEP)? ◯Yes ◯No Current 504 Plan? ◯ Yes ◯ No

Has your child been suspended from school? ◯ Yes ◯No If yes, what grade(s)?

What behaviors led to being suspended?

Describe any problems brought to your attention by teachers:

SECTION 8: SEXUAL INFORMATION / HISTORY

(Select all that apply)

- ☐ Begun Dating
- ☐ Begun Puberty
- ☐ Birth Control
- ☐ Currently Pregnant
- ☐ Difficulties with Sexual Orientation
- ☐ Excessive Anxiety
- ☐ Excessive Flirting
- ☐ Gender Identity
- ☐ Previous Pregnancy
- ☐ Sexually Active
- ☐ Sexually Reactive Behavior
- ☐ Sexually Transmitted Disease
- ☐ Other (explain below)

Description of Sexual History/ Concerns:

SECTION 9: TRAUMA HISTORY

Check all that apply and then describe below

- ☐ Accidents, e.g., care accidents
- ☐ Assault
- ☐ Attacked by an animal
- ☐ Care provider mental illness
- ☐ Community violence
- ☐ Contact with a sexual offender
- ☐ Death of someone important to child
- ☐ Domestic violence
- ☐ Emotional abuse
- ☐ Exploitation
- ☐ Illness
- ☐ Incarceration
- ☐ Natural disasters
- ☐ Physical abuse
- ☐ Physical abuser
- ☐ Rape
- ☐ Separation from caregiver/parent
- ☐ Sexual abuse- victim
- ☐ Sexual abuse- perpetrator
- ☐ Sexually Inappropriate with someone else
- ☐ Suicide/ attempts
- ☐ Verbally abused, e.g., name calling, etc
- ☐ Witness to physical or sexual abuse
- ☐ Other (explain below)

Description of Trauma History and concerns:

If child has any physical, or sexual abuse, please indicate by whom abuse occurred

If the child has contact with a person who is a sex offender please list person name

SECTION 10: CHILD'S LEGAL HISTORY

Current Legal Status: (Check all that apply)

- ☐ CINA
- ☐ Consent Decree
- ☐ Formal Probation
- ☐ Informal Probation
- ☐ Other Police Involvement
- ☐ No Legal Involvement
- ☐ Unknown

Is Child under Court Order? ○ Yes ○ No Date of Adjudication:

SECTION 11: CHILD'S SUBSTANCE USE HISTORY/EXPOSURE

Child has a History of Substance Use? ○ Yes ○ No ○ Unknown

Early Childhood Exposure to Substance Use? ○ Yes ○ No ○ Unknown

Previous Substance Abuse Services? ○ Yes ○ No ○ Unknown

Substance Use: (if indicated a history of substance use-check all that apply)

- ☐ Alcohol
- ☐ Barbituates
- ☐ Benzodiazepines (Xanax,Klonopin)
- ☐ Caffeine
- ☐ Club Drugs/Hallucinogens
- ☐ Cocaine/Crack
- ☐ Heroin
- ☐ Inhalants
- ☐ Marijuana
- ☐ Methamphetamine
- ☐ Opiates
- ☐ Over the Counter
- ☐ Stimulants
- ☐ Synthetic Marjijuana
- ☐ Tobacco/Nicotine
- ☐ Other(explain below)

Description of Substance Use and/or Substance Abuse Services (including other involvement with drugs, dealing drugs):

Has your child experienced legal, behavioral or social consequences from the use of alcohol or drugs? If yes, explain.

SECTION 12: FAMILY EXPECTATIONS (ORCHARD PLACE CAMPUS FAMILIES ONLY)

What do you expect Orchard Place Campus to do for you and your family?

What are your child's strengths?

What do you think the family treatment goals should include?

What do you think your child's treatment goals should include?

What does he/she need to do to return home?

SECTION 13: FAMILY PARTICIPATION REQUIREMENTS

When one member of a family comes to Orchard Place Campus, the whole family shares concerns, worries, and the discomfort of separation. Regularly scheduled family therapy sessions and visitation will be planned by you and your family's therapist. Family sessions will be regularly scheduled and you may set up visits with your child through your family therapist.

Weekly family therapy sessions are required. At a minimum, twice per month in-person sessions are required with phone or Skype sessions on the opposite weeks. Having all sessions in-person are preferred, when possible. Family therapy occurs between the hours of 8a—5p Monday-Friday.

Will you be able to participate weekly? ◯ Yes ◯ No

Preferred session day and time:

Do you have the capabilities for Skype sessions? ◯ Yes ◯ No

Do you have means of getting to your appointments at the Orchard Place Campus? ◯ Yes ◯ No

Will you be able to visit your child regularly on campus? ◯ Yes ◯ No

When your child has progressed in treatment, will you be able to have your child come home for visits? ◯ Yes ◯ No

In addition to family therapy, we also ask out parents/guardians to attend scheduled Psychiatric Review/Treatment Planning Sessions, or staffings, as part of the treatment team. Staffings provide an opportunity to hear progress reports from the unit, school, therapist and psychiatrist as well as participate in treatment planning and review. These are held around 30 days after admission and every quarter thereafter. Staffings are held during normal business hours to accommodate the psychiatrist schedules and any other professionals involved in your child's treatment.

Would you be able to attend regularly scheduled staffings? ◯ Yes ◯ No

Would you be able to attend informational trainings/parenting classes/support groups? ◯ Yes ◯ No

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To my knowledge, the above information is complete and accurate. I understand that failure to provide information could result in unsuccessful treatment.

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