Client Name: _____


_____ Date Received

925 SW Porter Avenue, Des Moines, Iowa 50315
(515) 287-9615 or (515) 287-9628 or (515) 287-9712
FAX: (515) 287-9683

# REFERRAL APPLICATION
# FOR PSYCHIATRIC MEDICAL INSTITUTE FOR CHILDREN

Child's Full Name: _____ Date of Birth: _____

Social Security # :_____ County of child's home: _____

Is child under a court order: ____ No _____Yes, CINA ____, Delinquent ____

Primary Insurance: _____
Policy Number: _____ Plan: _____
Policy Holder's Name: _____ DOB: _____
Employer:_____

Secondary Insurance: _____
Policy Number: _____ Plan: _____
Policy Holder's Name: _____ DOB: _____
Employer:_____

Dental Insurance: _____
Policy Number: _____ Plan: _____
Policy Holder's Name: _____ DOB: _____
Employer:_____

*Please attach copies of both sides of all insurance &/or Medicaid cards.*

## FAMILY

Mother: _____
Mother's Address: _____
Home #: _____ Work #: _____ Cell #: _____

Father: _____
Father's Address: _____
Home #: _____ Work #: _____ Cell #: _____

If applicable,
Stepfather: _____
Home #: _____ Work #: _____ Cell #: _____

Client Name: _____

Stepmother: _____
Home #: _____ Work #: _____ Cell #: _____

Other Caretakers: _____
_____

Brothers/Sisters Names, Ages, Where Living: _____
_____

Additional Family Info: _____
_____

Who does child normally live with: _____

Where is child living now: _____

If out of home, date placed at this location: _____

Last date lived at home: _____

---

**PROFESSIONAL CONTACTS**

Does child have a DHS worker-
Name of worker, address & phone number :_____
_____

Does child have a Juvenile Court or Probation Officer-
Name of worker, address & phone number :_____
_____

Does child have an Attorney or Guardian Ad Litem assigned-
Attorney's name, address and phone number: _____
_____

Who is currently treating your child:
Name/Agency/Phone Number:_____
Date started & ended: _____
Circle type of care- Outpatient Day Treatment/Partial Hospitalization Hospital
In-Home PMIC Residential Treatment Other

Name/Agency/Phone Number:_____
Date started & ended: _____
Circle type of care- Outpatient Day Treatment/Partial Hospitalization Hospital
In-Home PMIC Residential Treatment Other

Who has treated your child in the past-
Name/Agency/Phone Number:_____
Date started & ended: _____

Client Name: _____

Circle type of care- Outpatient Day Treatment/Partial Hospitalization Hospital
In-Home PMIC Residential Treatment Other

Name/Agency/Phone Number:_____
Date started & ended: _____
Circle type of care- Outpatient Day Treatment/Partial Hospitalization Hospital
In-Home PMIC Residential Treatment Other

Name/Agency/Phone Number:_____
Date started & ended: _____
Circle type of care- Outpatient Day Treatment/Partial Hospitalization Hospital
In-Home PMIC Residential Treatment Other

Name/Agency/Phone Number:_____
Date started & ended: _____
Circle type of care- Outpatient Day Treatment/Partial Hospitalization Hospital
In-Home PMIC Residential Treatment Other

Comments regarding previous treatment(s): _____
_____
_____
_____
_____
*Please use additional pages if necessary*

**PSYCHIATRIC/MEDICAL INFORMATION**

Child's Diagnosis: _____
_____
_____

Child's current medications and dosages:
_____
_____
_____
_____
_____

Any medical conditions: _____
_____

Has your child ever needed to be restrained or used a seclusion room:
_____

Height: _____ Weight: _____

Who is recommending Orchard Place for your child: _____
_____

Client Name: _____

Reason for referral (please include specific behaviors and attach additional sheets as necessary). Please note any history of sexual acting out, running away, aggression, self harm or substance abuse:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**SCHOOL INFORMATION**

Home School, Address & Phone #: _____
_____

Grade: _____ Credits Earned (if applicable): _____ of _____

Individualized Education Plan _____ _____
Yes No

504 Plan _____ _____
Yes No

Comments about school: _____
_____
_____

**FAMILY INVOLVEMENT**

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

Weekly face to face family therapy sessions are preferred. At the minimum, twice per month face to face sessions are required with phone sessions the other weeks. Will you be able to participate weekly?

_____

Client Name: _____

Do you have means of getting to your appointments at the Orchard Place campus?

_____

Will you be able to visit your child regularly on campus?

_____

When your child has progressed in treatment, will you be able to have your child come home for visits?

_____

In addition to family therapy, we also ask our 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?

_____

Would you be able to attend informational trainings/parenting classes/support groups as recommended by your family therapist?

_____

**GOALS**

What do you hope to accomplish during treatment:

_____
_____
_____
_____
_____
_____

Where will child go after treatment:

_____
_____
_____

Additional Comments:

_____
_____
_____

Person Completing Form (please print): _____
Relationship to child: _____
Phone (if not listed previously) _____
*Please return form to the Admissions Office at Orchard Place. 7/14 ldw*