CHILEDA RESIDENTIAL REFERRAL APPLICATION

As the information in this referral application will help determine if Chileda's services are a match for the child's needs, it is very important to complete all areas of the application in as much detail as possible.

STUDENT INFORMATION		
Student Name:		DOB:
Gender:	Height:	Weight:
Mother's name:	Father's name:	
Mother's address:	Father's address (if different than mother's address):	
Guardian's name (if other than parent):	Guardian ad Litem (if applicable):	
Referring agency:	Referring worker name:	
Referring worker phone number:	Referring worker email:	
School District of Enrollment/LEA: School District of Attendance (if different than District of Enrollment/LEA:	Date of current IEP:	Date of current 3-year evaluation:
Primary diagnosis:		
Secondary diagnosis:		
Reason for referral:		

CURRENT LIVING ARRANGEMENT	
Please describe who your child lives with:	
Address:	
Current Placement Contact Name (if applicable):	Phone Number:

OUT OF HOME PLACEMENT TYPE (GROUP HOME, FOSTER HOME, HOSPITALIZATION)		
RESIDENCE/FACILITY	**DATES/LENGTH OF STAY**	**REASON FOR PLACEMENT AND DISCHARGE**

CHILEDA RESIDENTIAL REFERRAL APPLICATION

ANY COURT/LEGAL/LAW ENFORCEMENT INVOLVEMENT IN PLACE OR PENDING FOR THE CHILD/YOUTH: ☐ Not Applicable		
Specify if CHIPS, JIPS, Delinquency and include exp date	Specify Reason for Court Involvement or Charges	Specify if Court Orders are Pending, Current/Active, or Discontinued (include dates):

BEHAVIOR INFORMATION: SECTION 1					
	Check Behaviors Child Displays	Check all that apply	How Often Does the Behavior Occur? (Hourly, daily, weekly, etc.)	Severity of Behavior **(please check box)**	Has this behavior caused injury? **If yes, please describe in section 2:**
	Hitting	☐ Self ☐ Others ☐ Both		☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Kicking	☐ Self ☐ Others ☐ Both		☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Biting	☐ Self ☐ Others ☐ Both		☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Hair Pulling	☐ Self ☐ Others ☐ Both		☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Scratching	☐ Self ☐ Others ☐ Both		☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Destroying Property			☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Loud Vocalizations			☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Elopement/Vacating			☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Run Away Behavior			☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Fecal Smearing			☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Disrobing			☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Forced Vomiting			☐ Low ☐ Medium ☐ High	☐Yes ☐ No
	Other:			☐ Low ☐ Medium ☐ High	☐Yes ☐ No

BEHAVIOR INFORMATION: SECTION 2
What tends to make the child upset?
What does a typical behavioral episode look like from beginning to end?
What appears to help calm the child, and help the incident to end.

Have any of the above behaviors caused injury to others (family, peers, staff, etc.)? If so, describe the types of injuries as well as their severity.
Have any of the above behaviors caused injury to the child/youth? If so, please describe the types of injuries as well as their severity.
Has the child required restraint and/or seclusion in the past or present? If so, when was the last time this was required, and how often is this currently needed?
Has the child engaged in any sexualized behavior or sexualized talk? If so, what do these behaviors look like?
Does the child imitate peer's behaviors, or are they easily influenced to engage in behaviors by a peer?
Does the child have a history of instigating other peers to engage in behaviors? If so, please describe what this looks like.
When are behaviors least likely to occur?
When are behaviors most likely to occur?
Please provide any other additional information regarding behaviors here.

STUDENT'S PERSONAL MENTAL HEALTH HISTORY	
CHECK ALL THAT APPLY	**Present psychological difficulties for your child**
	Generalized Anxiety (across many situations)
	Specific fears/phobias **List:**
	Panic Attacks
	Social Anxiety
	Obsessive thinking or compulsive behaviors **List OCD thoughts and/or behaviors your child presents with:**
	Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
	Sadness or depression
	Emotionally overwhelmed
	Frequent crying
	Loss of energy
	Loss or pleasure in life

	Suicidal Ideation: Does the child/youth have thoughts of suicide/suicidal ideation? If so, please describe the types and frequencies of these thoughts.
	Suicide Attempts: To what degree (seriousness and number of attempts) has the child/youth engaged in these suicidal attempts?
	Aggressive Ideation: Does the child/youth have any known ongoing thoughts/make comments regarding harming others? If so, when does this occur, what type of threat is noted, and what is the likelihood of action?
	Harm to Animals: Does the child/youth have a history of harming animals. If so, please describe the type and severity of this behavior.
	Problems sleeping through the night **What do the sleeping problems look like?**
	Trouble waking up
	Fatigue/tiredness during the day
	Nightmares
	Problems with attention or concentration
	Racing thoughts **What are the thoughts that tend to race in your child's mind?**
	Problems making or keeping friends
	Problems controlling temper
	Problems with maintaining healthy/appropriate boundaries

HISTORY OF ABUSE/TRAUMA (emotional, physical, sexual): ☐Yes ☐ No If No, please proceed to COUNSELING HISTORY
Has the child had any traumatic experiences (including abuse)? If so, please describe the type(s) of trauma, age when the trauma occurred, and frequency of the traumatic event(s):
If the child has experienced abuse, please describe the type(s) of abuse, age when the abuse occurred, and frequency of the abuse:
How does the trauma/abuse listed above impact the child's functioning (i.e., coping, reasoning, building and maintaining relationships)?
Does the child re-enact any traumatic events? If so, please explain:

Does the child have any known triggers in relation to the abuse/trauma?

COUNSELING HISTORY

Describe any previous mental health/counseling/therapy services your child has received (evaluations and therapy):

If your child did participate in counseling in the past, what was successful, and what did not appear to help?

COMMUNICATION AND SOCIAL SKILLS

Tell us how your child communicates with others, including regarding their wants and needs:

☐ Verbally (full sentences) ☐ Verbally (1-2 word utterances)
☐ Sign Language
☐ Picture Exchange Communication System (PECS)
☐ Communication Device/Voice Output Device (Describe)
☐ Gestures

SENSORY

What kind of sensory input does your child seek? ☐None
☐deep pressure ☐swinging ☐rocking ☐spinning ☐oral input ☐fidgets ☐bouncing
Other:

What kind of sensory equipment does your child seek? ☐None
☐Muffling earphones ☐weighted vest/blanket ☐bean/rice bucket ☐chewies
Other:

SCHOOL INFORMATION

Current school attendance: ☐Full day ☐ Half day ☐ Not in school

Describe a typical school day:

My child's favorite school subject is:
My child's least favorite school subject is:
My child does best in school when:

SAFTEY SKILLS AND COMMUNITY INVOVLEMENT
Tell us which safety skills your child knows. Which safety skills would you like them to learn?
Tell us about how your child does in the community. What are their strengths? What are some things you would like them to learn?

HEALTH INFORMATION		
Does your child have a history of substance abuse? ☐ Yes ☐No If yes, Chileda is not able to enroll children due to this factor (in relation to our current programming focus).		
Immunizations: ☐ Current ☐ Not current		
Allergies:	Y/N	Explain/Reactions
Drug allergies		
Food allergies		
Seasonal allergies		
Other:		

Nutrition	
Does your child have special dietary needs (i.e. such as lactose intolerant, diabetes, or a history of an eating disorder)? ☐ Yes ☐ No If yes, explain the special needs:	
Meal Times	
Speed of eating: ☐ Fast ☐ Normal ☐ Slow Please describe:	Susceptible to choking: ☐Yes ☐ No Please describe:
Assistance with eating: ☐No assistance needed, can feed self ☐Some assistance needed ☐Full assistance needed Please describe:	
Does your child require special equipment or supports during meal times? ☐Yes ☐ No	

CHILEDA RESIDENTIAL REFERRAL APPLICATION

If yes, please explain:
Is your child able to help prepare a meal with assistance? ☐Yes ☐No
What food does your child enjoy?
Tell us about meal time and what that looks like:
Medications
My child takes medications (check all that apply): ☐Pill form ☐Whole ☐Crushed ☐ mixed in applesauce/yogurt ☐Liquid form ☐Other: _____
My child takes medication at the following times each day:_____
Other
How will we know if your child is not feeling well or having pain?
Please describe any other underlying health concerns we should know about (ex. bruises easily, dry skin in the winter, high pain tolerance, etc.,)

WHAT DO YOU HOPE YOUR CHILD WILL TAKE AWAY FROM THEIR ENROLLMENT AT CHILEDA?
What would you like to see accomplished during your child's time at Chileda?
Describe any concerns you may have if you child is enrolled at Chileda:

_____ _____

Signature of Person Completing Application Date Completed

_____

Name of Person Completing Application (Please Print)

All information will be kept confidential and used for referral purposes only