220 Railroad Street SE Pine City, MN 55063
Phone (320) 629-7600 Fax (651) 925-0071

DAY TREATMENT REFERRAL FORM

☐ Pine City ☐ North Branch	☐ Elementary ☐ Middle	☐ Middle 2 ☐ Oldest

Admit Date:

Client Full Name: _____ Date of Birth: _____ Sex: _____ Age: _____

Client #: _____

Date of Referral _____ Referral Source: _____

Why referral source believes DT is appropriate service to meet client needs:

School: _____ IEP Yes No

Contact Person (specify role):

504plan: Yes or No

Grade: _____

Contact Phone Number:

Email Address:

DA or Psych Evaluation Complete: YES NO Needs Update

Day Treatment Recommended in DA? YES NO

☐ Addendum Completed as Needed

Providers: _____

Individual Therapy: _____ Family Based Services: _____

Family Therapy: _____ School Based: _____

Group: _____ Primary: _____

PMAP or MA #: MA _____

Insurance Name: _____

Insurance Number: _____

Legal Status: (check one)

- ☐ Parents Have Custody/Voluntary Placement
- ☐ Parents Have Custody/Court Ordered Placement
- ☐ State Ward
- ☐ Other: _____

Parent's Marital Status: Married Single Divorced Separated

Custody Arrangements:

Child's Race: (Check All That Apply)

☐ Caucasian ☐ Native American ☐ Asian-Pacific Islander ☐ Other (Specify)
☐ African American ☐ Eskimo-Aleutian ☐ Hispanic _____

Parent(s) Name:
Relationship:
Address:

Home Phone: Work Phone:

Other Parent(s) Name:
Relationship:
Address:

Home Phone: Work Phone:

Siblings Names and Addresses:

In Case of an Emergency Contact

Name:

Phone Number:

Relationship:

Should Not Have Contact With:

Others Providers Involved: Social Worker, Probation Officer, Outside Providers, Etc.

Name: Role: Work Number: ( ) Email:	Name: Role: Work Number: ( ) Email:
Name: Role: Work Number: ( ) Email:	Name: Role: Work Number: ( ) Email:

Allergies (Red Flag):

Special Medical Needs (i.e. asthma, seizures, etc.)

Transportation Requirement (check required):
___Booster ___Backseat

All children under age 8 must ride in booster seat unless the child is 4'9" or taller. 12 years and under must ride in back seat.

Current Medications (Name, Dosage, Frequency, Prescribed By, and Any Other Applicable Notes):

Past Services Received (Providers, Services, Dates):

Risk Factors Considerations:

Chemical Use:

Harm Towards Self:

Aggression Towards Others:

Holds:

Sexual Safety Concerns:

Runaway Behaviors (past or current concern):