

LEO A. HOFFMANN CENTER, INC.
1715 Sheppard Drive - P.O. Box 60 • St. Peter, MN 56082
Telephone: (507)934-6122 • FAX: (507)934-2594
www.hoffmanncenter.org

REFERRAL GUIDELINES

Please fill out completely and return to Leo A. Hoffmann Center with referral information.
Thank you! Date: _____

SERVICE REQUESTED: Assessment Treatment Shelter
 Outpatient Psychosexual Assessment Outpatient Therapy Services

REQUESTED PLACEMENT IS: Court Ordered Voluntary

Client's Name: _____

First

Middle

Last name

Current Residence: _____

City/State/Zip Code: _____

Date of Birth: _____ Place of Birth: _____

Social Security #: _____ Religious Affiliation: _____

Cultural Heritage: _____

Mother's Name: _____ Telephone: _____

Address: _____

City/State/Zip Code: _____

Father's Name: _____ Telephone: _____

Address: _____

City/State/Zip Code: _____

Any restrictions on either parents' involvement? If so, what? _____

Who is the Legal Guardian/Advocate of the client: _____

Address: _____ Telephone: _____

Who has custody of the client? _____

Parental Rights Terminated? ___ Yes ___ No

Sibling(s) Name:	Age:	Relationship:	Sibling(s) Name:	Age:	Relationship:

Chronological List of Treatment Services Received and/or Previous Out-of-Home Placements

Criminal Charges:

Specific Charge:	Adjudicated? Y N	Date
1.		
2.		
3.		
4.		
5.		

Is the client required to be registered with the BCA as a sex offender? ___ Yes ___ No

Has this been completed? ___ Yes ___ No

Current medication this client is prescribed:

Medication	Prescribed by:	Address/Phone #:

Any known allergies or relevant medical/physical/mobility concerns? _____

IQ LEVEL:	READING LEVEL: Need help with testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please Include the Following with the Referral Material:

Residential Treatment Services Only:

- Recent Social History
- Recent Psychological
- Police Reports
- Copy of Court Orders
- School Records (IEP)
- Psych. Evaluations/Reports
- Copy of Permanency Plans
- Immunization Records
- Medical History Information (3 years)
- Copy of Out of Home Placement Plans
- Pre-Placement Screening

Outpatient Services Only:

- Recent Social History
- Recent Psychological
- Police Reports
- School Records (IEP)
- Copy of Court Orders
- Psych. Evaluations/Reports
- All Other Pertinent Info.

A Functional & Diagnostic Assessment and Pre-Placement Screening must be enclosed. We may not do a placement without this assessment. *(Residential only)

Person Making Referral:

Name: _____ Telephone: _____
Agency: _____ FAX: _____
Address: _____
Email: _____

Please list other Court Service/Social Service/Guardian Ad Litem/Dispositional Advisor individuals involved in this case:

Name: _____ Telephone: _____
Agency: _____ FAX: _____
Address: _____
Email: _____

Name: _____ Telephone: _____
Agency: _____ FAX: _____
Address: _____
Email: _____

Billing Information: (Agency responsible for Per Diem)

Name: _____ Telephone: _____
Agency: _____ FAX: _____
Address: _____
Email: _____

Financial Worker's Name (if applicable): _____

Insurance & Medical Assistance Information Form

Client Name _____

Date of Birth: _____

Client SSN: _____

Date of Admission: _____

I DO NOT HAVE ANY MEDICAL/HEALTH INSURANCE COVERAGE.

Please give us all the pertinent information regarding your insurance coverage. If you have coverage by more than one insurance policy please give information for all policies. This information is needed for our medical/dental providers to file insurance claims. Some insurance companies *will not accept claims without the insured's date of birth*. Please fill in all information requested. If this information is not submitted, Hoffmann Center will bill the county for all medical expenses until all required insurance information is received. Please bring a copy of *both the front and back* of all insurance and Medical Assistance cards or the original cards to admission.

Please note Leo A. Hoffmann Center bills insurance on residential clients only

<u>PRIMARY INSURANCE CARRIER</u>	<u>MEDICAL ASSISTANCE</u>
Plan Name _____	Medical Assistance # _____
Address _____	
Telephone # _____	
Name of Insured _____	
Relationship to Patient _____	
Birthdate of <u>Insured</u> _____	
Insured ID Number _____	
Group/Account Number _____	
Name of Insured's Employer _____	
Effective Date _____	
<u>SECONDARY INSURANCE CARRIER</u>	<u>OTHER INSURANCE CARRIER(Dental, etc.)</u>
Plan Name _____	Plan Name _____
Address _____	Address _____
Telephone # _____	Telephone # _____
Name of Insured _____	Name of Insured _____
Relationship to Patient _____	Relationship to Patient _____
Birthdate of <u>Insured</u> _____	Birthdate of <u>Insured</u> _____
Insured ID Number _____	Insured ID Number _____
Group/Account Number _____	Group/Account Number _____
Name of Insured's Employer _____	Name of Insured's Employer _____
Effective Date _____	Effective Date _____

ADMISSIONS MEDICATION CONSENT FORM
***(Residential Referral Only)**

Clients referred to Leo A. Hoffmann Center programs are admitted with previously prescribed medications intended to improve their health, influence their moods, or influence their behavior. Some have had complete and appropriate evaluations before those medications were begun, but many have not. The initial evaluation of all new clients admitted to Hoffmann Center, except crisis shelter admissions will include a review of past psychiatric and psychological assessments, and a psychiatric screening interview by our consulting psychiatrist. Our consulting psychiatrist will make recommendations regarding need for further evaluation of conditions already being treated. He may make recommendations regarding changes in medication and will be the prescribing psychiatrist during your child's stay at Hoffmann Center.

Every effort will be made to continue medications, which are still necessary, but you should also expect to be advised of any recommended additional assessments or proposed changes in medication. Valid informed consent will be obtained from parents or legal guardians, by the Registered Nurse, before any medications for the management of moods or behavior are begun or discontinued. No changes in medications already prescribed are ordinarily made during the assessment period.

In order to assure that your child may continue to receive medications already prescribed, please provide us with the following information: **(1) name of medication, (2) dose, (3) medication schedule, (4) doctor's name, and (5) the reason the client is taking the medication.** For example: Ritalin, 10 mg in the morning and 5 mg at noon, Dr. Smith for ADHD. (This information is on the label of the bottle of pills or a written prescription from their present physician).

Medication Name:
Dose:
Medication Schedule:
Dr.'s Name/Facility:
REASON:

Medication Name:
Dose:
Medication Schedule:
Dr.'s Name/Facility:
REASON:

Medication Name:
Dose:
Medication Schedule:
Dr.'s Name/Facility:
REASON:

Medication Name:
Dose:
Medication Schedule:
Dr.'s Name/Facility:
Reason:

Medication Name:
Dose:
Medication Schedule:
Dr.'s Name/Facility:
Reason:

Medication Name:
Dose:
Medication Schedule:
Dr.'s Name/Facility:
Reason:

I consent to the Leo A. Hoffmann Center staff administering the above medication(s).

Parent or Legal Guardian: _____

Client: _____ Date: _____

REFERRAL FORM FOR EDUCATIONAL SERVICES
***(Residential Referral Only)**

Please complete the following questionnaire and return to Leo A. Hoffmann Center with the referral information. **It is important that you thoroughly respond to all requested information!** Thank you!

Student Name:		Date of Birth:
Custodial Parent/Guardian:		
Address:		
Language:		Race:
County:		School District #:
Resident District Name:		Grade:
Name and Address of School Student is <u>Currently</u> Attending:		

Previous Schools Attended
 (Please complete even if school documents have been sent as this gives the Hoffmann Learning Center the information needed to begin the child in school.)

Name:	Name:	Name:
Address:	Address:	Address:
Contact Person (if known):	Contact Person (if known):	Contact Person (if known):

Does the student have an Individual Education Plan (IEP)? Yes No

**RELEASE OF INFORMATION - To Hoffmann Learning Center
 *(Residential Referral Only)**

I, _____, hereby authorize the **Leo A. Hoffmann Center, Inc.** to exchange information regarding _____ with **Teresa Saum, Educational Coordinator, Hoffmann Learning Center, ISD #508, St. Peter School District, St. Peter, MN 56082** the following information:

- | | |
|--|---|
| <input type="checkbox"/> Medical Records
<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Psychiatric Reports
<input type="checkbox"/> Court Records | <input checked="" type="checkbox"/> Educational Records
<input type="checkbox"/> Case Progress/Reviews/Reports
<input type="checkbox"/> Social History/Assessments
<input checked="" type="checkbox"/> Referral material produced by other agencies, organizations, and individuals
<input type="checkbox"/> Other: _____ |
|--|---|

for the following purpose: To coordinate treatment planning.

I have been instructed as to what information will be released, the purpose and intended use of the released information, who will receive the information, and any known consequences of this release. The information to be released is private, and any subsequent use and release is controlled under the Minnesota Data Practices Act (MN Stat. 1982 Chap. 13).

I have been informed of my right to refuse to release this information.

I understand that I may revoke this consent upon written notice (not retroactive) and that the consent will automatically expire within one (1) year after the date of my signature.

Name	Client	Date
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Name	Relationship	Date
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Name	Relationship	Date
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Witnessed By	Title	Date
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