



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:**  
 (Please bring *at least* a 30-day supply of medication along with you on day of admission.)

Medication	Prescribed by:	Address/Phone #:

Any known allergies or relevant medical/physical/mobility concerns? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>IQ LEVEL:</b>	<b>READING LEVEL:</b> 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\*

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

**(Please bring at least a 30-day supply of medication along with you on day of admission.)**

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

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

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

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

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

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

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

Parent or Legal Guardian: \_\_\_\_\_

Client: \_\_\_\_\_ Date: \_\_\_\_\_

**RELEASE OF INFORMATION – MEDICAL RECORDS**  
(Last medical facility completing client's physical)

I, \_\_\_\_\_, hereby authorize Leo A. Hoffmann Center, Inc. to exchange the following information  
with:

\_\_\_\_\_, \_\_\_\_\_  
(Name) (Agency)  
\_\_\_\_\_  
(Address)  
\_\_\_\_\_  
(Telephone Number) (Fax Number)

**Regarding:**

\_\_\_\_\_  
Name – Last, First, MI Date of Birth

**1a. Type of information to be disclosed.**

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Medical Records  | <input type="checkbox"/> Educational Records           |
| <input type="checkbox"/> Psychological Testing   | <input type="checkbox"/> Case Progress Reviews/Reports |
| <input type="checkbox"/> Psychiatric Assessment/Reports/Notes  | <input type="checkbox"/> Social History/Assessments    |
| <input type="checkbox"/> Court Records   | <input type="checkbox"/> Psychotherapy Notes           |
| <input type="checkbox"/> Exchange of verbal communication  | <input type="checkbox"/> Substance Abuse/Dependency    |
| <input type="checkbox"/> Exchange of other specific information (i.e. polygraphs or photographs). Specify information to be exchanged: _____ |  |

**b. Are there any limitations to the release of information?**  Yes  No  
If yes, please specify: \_\_\_\_\_

**2. Purpose or need for disclosure.**

- |   |   |                                    |                                   |
|---|---|------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> further medical care              | <input type="checkbox"/> legal investigation                                    | <input type="checkbox"/> insurance | <input type="checkbox"/> personal |
| <input type="checkbox"/> evaluation                                   | <input type="checkbox"/> To obtain immunization records/general medical records |                                    |                                   |
| <input type="checkbox"/> To coordinate the treatment planning process | <input type="checkbox"/> Other: _____   |                                    |                                   |

**3. This authorization may be revoked in writing at any time prior to the disclosure of this information. This authorization will expire on (date) or no more than one year from the date of your signature. Revocation of this authorization must be made in writing to: Leo A. Hoffmann Center, Inc. 1715 Sheppard Drive • P.O. Box 60 • St. Peter, Minnesota 56082**

By signing this authorization, you understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material to be disclosed and **copies of records may be obtained with reasonable notice and payment of copying costs.**

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

If signed by a person other than the client, state relationship and authority to do so.

Client is Legal Authority  Minor  Legal Guardian  Biological Parent of Minor  Other: \_\_\_\_\_

\_\_\_\_\_  
Client Signature (if of legal age and no guardianship assigned)

\_\_\_\_\_  
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!

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

### 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.)

<b>Name:</b>	<b>Name:</b>	<b>Name:</b>
<b>Address:</b>	<b>Address:</b>	<b>Address:</b>
<b>Contact Person (if known):</b>	<b>Contact Person (if known):</b>	<b>Contact Person (if known):</b>

**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 **Hoffmann Learning Center, ISD #508, St. Peter School District, St. Peter, MN 56082** the following information:

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

Witnessed By	Title	Date
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