

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
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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:
 (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? _____

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

Outpatient 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

- 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.

PRIMARY INSURANCE CARRIER

Plan Name _____
Address _____

Customer Service Telephone # _____

Name of **Insured** _____

Social Security Number of **Insured** _____

Birthdate of **Insured** _____

Insured ID Number _____

Group/Account Number _____

Name of Insured's Employer _____

Effective Date _____

Relationship to Patient _____

SECONDARY INSURANCE CARRIER

Plan Name _____

Address _____

Customer Service Telephone # _____

Name of **Insured** _____

Social Security Number of **Insured** _____

Birthdate of **Insured** _____

Insured ID Number _____

Group/Account Number _____

Name of Insured's Employer _____

Effective Date _____

Relationship to Patient _____

MEDICAL ASSISTANCE

Medical Assistance # _____

Does Patient have Dental Quest? ___Yes___No

Does Patient have PMAP? ___Yes___No

Name of County Worker _____

Telephone Number of County Worker _____

OTHER INSURANCE CARRIER(Dental, etc.)

Plan Name _____

Address _____

Customer Service Telephone # _____

Name of **Insured** _____

Social Security Number of **Insured** _____

Birthdate of **Insured** _____

Insured ID Number _____

Group/Account Number _____

Name of Insured's Employer _____

Effective Date _____

Relationship to Patient _____

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.)

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: _____

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 no more than one year from the date of your signature below. 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!

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

- | | |
|--|--|
| <input type="checkbox"/> Medical Records | <input checked="" type="checkbox"/> Educational Records |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Case Progress/Reviews/Reports |
| <input type="checkbox"/> Psychiatric Reports | <input type="checkbox"/> Social History/Assessments |
| <input type="checkbox"/> Court Records | <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

Name Relationship Date

Name Relationship Date

Witnessed By Title Date