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:
(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? ☐ Yes ☐ No

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**: _____

_____

_____ **Email:** _____

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

Name: _____ **Telephone**: _____

Agency: _____ **Fax**: _____

_____

_____ **Email:** _____

Name: _____ **Telephone**: _____

Agency: _____ **Fax**: _____

_____

_____ **Email:** _____

Billing Information: (Agency responsible for Per Diem)

Name: _____ **Telephone**: _____

Agency: _____ **Fax**: _____

_____

_____ **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

PRIMARY INSURANCE CARRIER

Plan Name
Address _____
_____
Telephone #_____
Name of Insured _____
Relationship to Patient_____
Birthdate of **Insured** _____
Insured ID Number_____
Group/Account Number_____
Name of Insured's Employer _____
_____
Effective Date_____

MEDICAL ASSISTANCE

Medical Assistance #_____

SECONDARY INSURANCE CARRIER

Plan Name _____
Address _____
_____
Telephone #_____
Name of Insured _____
Relationship to Patient_____
Birthdate of Insured _____
Insured ID Number_____
Group/Account Number_____
Name of Insured's Employer _____
_____
Effective Date_____

OTHER INSURANCE CARRIER(Dental, etc.)

Plan Name _____
Address _____
_____
Telephone #_____
Name of Insured _____
Relationship to Patient_____
Birthdate of Insured _____
Insured ID Number_____
Group/Account Number_____
Name of Insured's Employer _____
_____
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 *<u>at least</u>* 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).***

□ ***My son/client is not on any prescribed medication at this time.***

Parent or Legal Guardian: _____

Client: _____ Date: _____

RELEASE OF INFORMATION – MEDICAL RECORDS

(Last medical facility completing client's physical)

I, _____ 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.

X	Medical Records	☐	Educational Records
☐	Psychological Testing	☐	Case Progress Reviews/Reports
☐	Psychiatric Assessment/Reports/Notes	☐	Social History/Assessments
☐	Court Records	☐	Psychotherapy Notes
☐	Exchange of verbal communication	☐	Substance Abuse/Dependency

☐ 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.

X further medical care ☐ legal investigation ☐ insurance ☐ personal
☐ evaluation ☐ To obtain immunization records/general medical records
☐ To coordinate the treatment planning process ☐ 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**

RELEASE OF INFORMATION

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.

X	Medical Records	X	Educational Records
X	Psychological Testing	X	Case Progress Reviews/Reports
X	Psychiatric Assessment/Reports/Notes	X	Social History/Assessments
X	Court Records	X	Psychotherapy Notes
X	Exchange of verbal communication	X	Substance Abuse/Dependency

X 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.

☐ further medical care ☐ legal investigation ☐ insurance ☐ personal
X evaluation ☐ To obtain immunization records/general medical records
X To coordinate the treatment planning process ☐ 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

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

☐	Medical Records	X	Educational Records
☐	Psychological Testing	☐	Case Progress/Reviews/Reports
☐	Psychiatric Reports	☐	Social History/Assessments
☐	Court Records	X	Referral material produced by other agencies, organizations, and individuals
		☐	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