Triad Coordinated Services, Inc.
Referral/Screening/Application

Date of Referral/Application: _____

Who referred applicant? _____

Referral Phone # (if applicable): _____ _____

Client's Name: _____
Last First Middle Maiden

D.O.B. _____ Record #: _____

Medicaid ID #: _____ SS#: _____ Sex: _____

Allergies: _____

FAMILY/GUARDIAN INFORMATION:

Guardian Name: _____

Relationship to Client: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

CURRENT INFORMATION:

Current Provider(s) and Services (include dates): _____

_____

_____

Reason for Change/Discharge: _____

Number of Previous Placements: _____

Reason for Referral/Presenting Problem: _____

_____

_____

Strengths_____

Needs_____

Abilities_____

Preferences_____

CURRENT BEHAVIORAL/COGNITIVE ISSUES:

_____ Abandonment Issues	_____ Hyperactive	_____ Arson
_____ Alcohol/Drug Abuse	_____ Antisocial Behavior	_____ Stealing
_____ Assaultive (Physical)	_____ Assaultive (Sexual)	_____ Lying
_____ Assaultive (Verbal)	_____ Bedwetting	_____ AWOL
_____ Victim of Abuse	_____ Destroying Property	_____ Truancy
_____ Developmental Disability	_____ Academic Difficulties	_____ Impulsive
_____ Cruelty to Animals	_____ Difficulty with Authority	_____ Anxiety
_____ Loss/Grief Issues	_____ Perception of Reality	_____ Suicidal
_____ Neglect Issues	_____ Self Injury	_____ Oppositional
_____ Physical Disabilities	_____ Social Immaturity	_____ Homeless
_____ Eating Disorder	_____ Self Destructive	_____ Depression
_____ Low Self Esteem	_____ Sibling Related difficulty	_____ Unruly
_____ Sleep Problems	_____ Victim of Sexual Abuse	

Date of most recent Diagnostic Assessment and/or Evaluation: _____

INFORMAL DIAGNOSIS (as reported by guardian):

_____

_____

_____

_____

_____

_____

_____

_____

_____

NC-SNAP _____

CURRENT MEDICATIONS:

_____

_____

_____

SCHOOL INFORMATION:

Current School: _____

Grade: _____ Special Classes (Specify): _____

Current IEP (attach copy): _____

Grades Repeated: _____

Suspensions/Expulsions: _____

WORK HISTORY:

Current Work Placement: _____

Length of Time Employed: _____ Independent or Requires Assistance (Circle one)

Comment: _____

COURT HISTORY:

Has client been involved in court issues? _____ Yes _____ No

If YES, list Court and Outcome: _____

_____

Does client have any Pending Charges? _____ Yes _____ No

If YES, List all charges: _____

_____

_____

Court Counselor: _____ Phone #: _____

EXPECTATIONS/TREATMENT GOALS:

List needed/desired services:_____

List days and times services will be requested:

Mon_____**Tues**_____**Wed**_____**Thur**_____**Fri**_____

Sat_____ **Sun**_____

List client's expectations of TCS along with your goals (short/long-term and strategies):

_____

_____

_____

ATTACH A COPY OF MEDICAID CARD/IPRS VERIFICATION LETTER

Verification of Current Medicaid/IPRS Status _____

ASSESSMENT OF ABILITY TO MEET NEEDS OF CLIENT
(an assessment of whether or not the facility can provide services to address the individual's needs)

_____

_____

DISPOSITION OF REFERRAL/APPLICATION

Application accepted: _____ Yes _____ No

Recommendations/Referrals: _____

_____

Notification of Disposition of Referral: _____

Date of Admission: _____

_____ _____
Signature/Title of Triad Coordinated Services, Inc. Agent Date