

**CHRISTIAN CHILDREN'S HOME OF OHIO, INC. (CCHO)  
BRINGING HEALING TO HURTING CHILDREN AND FAMILIES...IN HIS NAME.**

**CHILDREN RESIDENTIAL REFERRAL APPLICATION**

**Today's Date:** \_\_\_\_\_

The following information will help us to obtain a better understanding of your child as quickly as possible. Please complete it to the best of your ability, but do not worry if you are unable to answer some of the questions. For responses requiring additional space, please use a separate sheet of paper. Thank you very much for your effort.

Child's full name:				Race:	Male	Female
				DOB:	Age:	
Hair Color:	Eye Color:	Ht.:	Wt:	Soc. Sec. #:	Current grade::	
Child's current address:				Phone #:	Fax #:	
City:				E-mail:		
State:		Zip:		Diagnosis:		
Current placement is: (Please circle)    Parent's home    Relative's home    Foster home    Hospital    Residential facility						
Date that child was placed:			Who has custody of the child?:			
Was this child adopted?:    Y    N			Date child was adopted:			
Guardian's Name:				Phone #:	Fax #:	
Address:						
City:				E-mail:		
Placing entity (If different then above):				Phone #:	Fax#:	
Address:				Emergency phone #:		
City, State, Zip:				Name of County worker?:		
Referred by: (If different than above):				Relationship to the child:		
Reason for referral:						
Medication	Dosage	How many?	How often?	Prescribing Doctor		
<b>Allergies:</b>						
Please list any discontinued psychotropic medications and why:						

**FAMILY BACKGROUND INFORMATION:** Please list all primary family members (birth/adoptive parents' stepparents, brothers, and sisters). Place a (x) next to the names of individuals who currently live in the home with the child:

Name	M F	Relationship to Child	Occupation/ Education Level	Age	Quality of Relationship
Parent's marital status: (Circle one) Married Divorce Separated Never Married Other _____					

**EMOTIONAL & BEHAVIORAL HEALTH INFORMATION:**

Is the child Adopted?	If so, when was the adoption finalized?			Private or Agency?:
<b>Abuse and Neglect History</b>	Yes	No	Maybe	If the child has been mistreated, to which county was mistreatment reported?
Sexually abused?				
Physically abused?				Were these reports investigated? Yes No (If yes, please attach the investigation finding).
Emotionally abused?				

**ACADEMIC HISTORY:** Please list the 3 recent schools, beginning with the most recent:

Name of School:	Dates attended	Grade K-12	IEP/MFE	Special Needs?
Address:			Y N	
City, State, Zip:				
Phone:	Fax:	Contact person:		
Name of School:	Dates attended	Grade K-12	IEP/MFE	Special Needs?
Address:			Y N	
City, State, Zip:				
Phone:	Fax:	Contact person:		
Name of School;	Dates attended	Grade K-12	IEP/MFE	Special Needs?
Address:			Y N	
City, State, Zip				
Phone:	Fax:	Contact person:		

**INSURANCE INFORMATION:**

	<b>Primary (Circle one)</b>	<b>Secondary (Circle one)</b>
Name of Policyholder:	Medicaid or Insurance	Medicaid or Insurance
Address of Insurance:	ID#:	ID#:
Phone#:	Group#:	Group#:

**HISTORY OF CURRENT PROBLEMS:** The current problems developed when the child was approximately at age \_\_\_\_\_. At that age, the following difficulties were noted (please list briefly):

1. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
2. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please indicate any events occurring around that time that you believe may be related to the problems noted above:**

Death in family	Divorce	Moving	Loss of loved one	Victim of abuses
Other (please describe briefly):				
How has the event(s) affected the child? What change(s) in the child have you noticed? Give examples (academic, social, etc.):				

**Overall, how would you describe the changes in this problem over time?**

	This is a recent and first-time problem for this child.
	This is a problem the child has had for awhile, but now it's getting worse.
	This is a problem the child has had for awhile, but now it's improving somewhat.
	This is a problem the child has had for awhile, and now it is just like it has always been.
	This is a problem that comes and goes in cycles.

**BEHAVIORAL FUNCTIONING:** To what degree has the child engaged in the following behaviors? (Please check the appropriate box)

? Unknown	=Never	2=Rarely)1-2x	3=Sometimes	4=Regularly	5=Very Often
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	?	1	2	3	4	5
Abnormal motor movements, jerks, tics of the face, neck, shoulders, mouth						
Annoys others deliberately						
Arrests						
Argumentative /angry/vindictive behavior						
Binge eating						
Court involvement						
Cruelty to animals or people						
Depressed/irritable/low interest/motivation/boredom/withdrawal from friends						
Difficulty following through on instructions						
Distractibility/Inattentiveness						
Fearful about being separated from you (at school, at night, being left with a sitter)						
Fears that harm will come to you/him/her during your absences (killed, accident)						
Fidgeting						
Fire setting						
Gang associations						
"Habits" that child just cannot seem to help						
History of frequent coughing, throat clearing, stuttering, or unusual noises						
Homicidal/dangerous behaviors or plans						
Impulsivity						
Increases tearfulness or lability of mood						
Keeping friends						
Loses things easily						
Lying						
Manipulative						
Multiple apparently unfounded medical complaints						
Openness to parents						
Openness to peers						
Openness to adults						
Over activity						
Painfully or excessively shy when with unfamiliar people						
Persistent concern with body shape/weight						
Physical aggression with kids						
Physical violence with weapons-adults						
Physical violence with weapon-kids						
Physical aggression-adults						
Preoccupation w/cleanliness, excessive hand washing or peculiar orderliness						

	?	1	2	3	4	5
Refuses to comply with reasonable rules						
Running away						
Sexual behaviors						
Sexual abuse to others						
Shifts from one incomplete activity to another						
Sleep or appetite/weight changes						
Soiling/wetting						
Stealing/forgery/breaking & entering						
Suicidal behavior/thoughts						
Suicidal threats/ attempts						
Swears/uses obscene language						
Unpleasant thoughts that go around in head or being afraid of something he might do						
Use of laxatives/diuretics/diet pills						
Verbally aggressive with adults						
Verbally aggressive with kids						
Substance use/abuse: (Circle all that apply): Alcohol Marijuana Cocaine Heroin Opiates LSD Tranquilizers Hallucinogens						
Does the child have issues with: Circle all that apply): Authority Younger Children Opposite Sex Older Children						
Please explain:						

Are there any other problems not already mentioned? \_\_\_\_\_

\_\_\_\_\_

What are the <b>major</b> problems for which the child is coming to the residential facility?							
Why is the child being referred to the residential facility <b>right now</b> as opposed to some other time?							
What do you hope to achieve by brining the child to the residential facility (check all that apply)?							
<input type="checkbox"/>	Evaluation	<input type="checkbox"/>	Second opinion	<input type="checkbox"/>	Letter to school/agency	<input type="checkbox"/>	Court ordered evaluation
<input type="checkbox"/>	Medication	<input type="checkbox"/>	Referral for therapy	<input type="checkbox"/>	Independent Living	<input type="checkbox"/>	Shelter Care Program
<input type="checkbox"/> Pressure to do so by another person or organization, but I'm not sure it is really necessary							
<input type="checkbox"/> Other:							

Has your child been tested for a learning/behavior disability? Y N	Date of Testing?
What was the outcome of the testing?	

**PREVIOUS PSYCHIATRIC HISTORY OF CHILD:** (please circle one)

Previous history of psychiatric/psychological drug or alcohol evaluation or treatment: Y N ?				
When?	Where?	With whom?	Why?	

Hospitalization, partial hospital programs or residential treatment programs:			Y	N	?
When?	Where?	With whom?	Why?		
History of suicide attempt(s): Y N ?					
When	Where?	With whom?	Why?		
Medications for psychiatric/emotional problems, now or in the past? Y N ? Please provide:					
Name of medications	Dosage	Date of Treatment	Response or reason for discontinuing		

**DEVELOPMENTAL HISTORY:**

During Pregnancy

Full term (38-42 weeks)?	Y	N	Eclampsia/pre-eclampsia, Y N
High blood pressure			Swelling
Elevated blood sugar			Urine protein
Alcohol use			Drug use
Other toxic substances to which mother was exposed			
Medications for the mother? Y N	(If yes, please specify)		
Other illnesses? Y N	(If yes, please specify)		

Labor and Delivery

Vaginal delivery?	C-section – emergency?
C-Section – planned or repeat?	Forceps used?

Infant's Condition at Birth

Birth weight of child?	Jaundiced? (yellow baby)
Was the child from the hospital within 3 days after birth?	
Other medical problems after birth?	

First Year of Life

Colicky?	Bond well?
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Milestones

Age at walking unassisted?:	Age baby spoke first words?
Age baby put 2 or 3 words together?	Age at toilet training?