REQUEST FOR SERVICE

(PLEASE FILL OUT ENTIRE FORM)

***** WE ACCEPT AGES 6-17 ONLY *****

DATE OF REQUEST FOR SERVICE: _____ ☐ **DCFS BED** ☐ **JUV. COURT BED**

REFERRED BY: _____ **AGENCY:** _____ **PHONE #:** _____

CLIENT'S NAME: _____ **AGE:** _____ **SEX:** ___ **CUSTODY:** ☐ DCFS ☐ PARENT

COUNTY: _____ **DATE OF BIRTH:** _____ **SS#:** _____

REASON FOR REFERRAL: _____

_____

HISTORY OF BEHAVIOR PROBLEMS (CHECK ALL THAT APPLY)

☐ RECENT HISTORY OF SUICIDAL OR HOMICIDAL IDEATIONS / ATTEMPTS ☐ YES ☐ NO
☐ CURRENTLY SUICIDAL ☐ CURRENTLY HOMICIDAL

☐ RECENT HISTORY OF AGGRESSION OR VIOLENT BEHAVIOR? ☐ YES ☐ NO

☐ RECENT HISTORY OF RUNNING AWAY *(AWOL)*? ☐ YES ☐ NO

☐ HISTORY OF SEX OFFENDING

☐ ANY PAST OR CURRENT GANG AFFILIATIONS

☐ HISTORY OF ARSON

☐ ABILITY TO TAKE CARE OF THEMSELVES

☐ SUSPENDED OR EXPELLED FROM SCHOOL

☐ HISTORY OF BEING PHYSICALLY RESTRAINED

☐ HAVE AN IEP? ☐ YES ☐ NO

☐ ANY CURRENT / PREVIOUS DRUG USE

☐ ANY PENDING / PREVIOUS CHARGES: _____

_____

☐ OTHER: _____

IF THE CLIENT HAS A HISTORY OF AGGRESSION OR VIOLENT BEHAVIOR, WAS IT VERBAL, PHYSICAL, OR BOTH? _____

WHAT AGGRESSIVE/VIOLENT BEHAVIORS HAS THE CLIENT RECENTLY DISPLAYED? _____

_____

IF THE CLIENT HAS A HISTORY OF SUICIDAL OR HOMICIDAL IDEATIONS/ATTEMPTS, WHAT WERE THE BEHAVIORS OR ACTIONS EXHIBITED? _____

_____

WHAT IS THE CLIENT'S IQ? _____

ANY ALLERGIES OR SPECIAL DIETS? _____

_____

MEDICAL/HEALTH ISSUES OR CONCERNS? _____

CURRENT DIAGNOSIS? _____

MEDICATIONS: ☐ YES ☐ NO **PLEASE LIST:** _____

_____

☐ **BLISTER PACKS REQUESTED?**

***** ALL MEDS MUST BE BROUGHT AT INTAKE. NO PRESCRIPTIONS WILL BE TAKEN *****

******* FOR DCFS CLIENTS ONLY *******

HOW LONG HAS THE CLIENT BEEN IN DCFS CARE? _____

_____

WHAT IS THE LONG-TERM PLAN? _____

_____

WHERE WAS THE CLIENT'S LAST PLACEMENT? _____

_____

WHY DID THE CLIENT LEAVE THE LAST PLACEMENT? _____

_____

FULL SHELTER DAYS AVAILABLE? ☐ YES ☐ NO **IF NO, HOW MANY ARE?**

COMMENTS: _____

_____

_____

_____

_____

_____

***** OCC REQUIRES A LETTER OF RECOMMENDATION FOR ALL CLIENTS COMING OUT OF ACUTE OR RESIDENTIAL CARE *****

WE CANNOT ACCEPT RESIDENTS THAT:

- HAVE ACTIVE PSYCHOTIC HALLUCINATIONS, DELUSIONS.
- ARE SEXUAL OFFENDERS.
- HAVE A SEIZURE DISORDER THAT IS NOT MANAGED/STABLE.
- ARE INSULIN DEPENDENT.
- HAVE EXCESSIVE PHYSICAL AGGRESSION TOWARDS PEERS OR STAFF.
- ARE PRESCRIBED HALDOL.
- HAVE STRICT FOOD ALLERGIES AND/OR SENSITIVITIES.
- ARE KNOWN TO BE PREGNANT.
- HAVE FECAL/URINARY INCONTINENCE THAT IS NOT MANAGED/STABLE.
- ARE MEDICATED TO A CATATONIC STATE.
- WE CANNOT PROVIDE ADEQUATE CARE TO, BASED ON THE LEVEL OF NEEDS.
- HAVE MEDICAL DEVICES SUCH AS INSULIN PUMP, C-PAP, ETC.

STAFF COMPLETING FORM: _____ **DATE:** _____

FOR OFFICIAL USE ONLY:

ACCEPTED: ☐ YES ☐ NO ****** IF NOT ACCEPTED, REASON WHY ******

☐ NO BEDS ☐ DID NOT MEET CRITERIA ☐ PART OF A SIBLING GROUP

PLACED: ☐ YES ☐ NO DATE & TIME OF INTAKE: _____

****** IF NOT PLACED, WHY ****** _____

_____

****BE SURE TO REQUEST A COMPLETE PLACEMENT HISTORY IF CLIENT IS ACCEPTED!****