# 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!****