REFERRAL PACKET INSTRUCTIONS

Please complete all the pages of this application. The items listed below are **REQUIRED** before a decision can be made regarding this referral. If this is a DPRS client, the Common Application Form is required as well.

REQUIRED DOCUMENTATION:

- ☐ Psychological Evaluation which includes I.Q. tests
- ☐ Psychiatric Evaluation (if Psychological was administered by school district)
- ☐ Two weeks progress notes (if applicable)
- ☐ Most recent Discharge Summary (if applicable)

LEGAL DOCUMENTATION REQUIRED:

- ☐ Copy of Birth Certificate
- ☐ Copy of Social Security Card
- ☐ Copy of Immunization Record
- ☐ Copy of Proof of Custody (if applicable)
  (i.e., Divorce Decree/Guardianship/Power of Attorney)
- ☐ Copy of Medicaid Card/Insurance Card (if applicable)
- ☐ Copy of W-2 or most recent tax return (first two pages only)

FAILURE TO INCLUDE THE REQUIRED DOCUMENTATION WILL RESULT IN A DELAY IN THE ACCEPTANCE AND/OR SCHEDULING OF AN ADMISSION DATE.

For information regarding ADMISSIONS/WAITLIST, please contact:

Laurie Mazza	**Lisa Reneau**
(254) 745-5302	**(254) 745-5175**

For information regarding PROGRAM COSTS/FEES, please contact:

Christina Salazar	**Cornelia Howard**
(254) 745-5122	**(254) 745-5131**

WACO CENTER FOR YOUTH REFERRAL PACKET

PARENT/GUARDIAN INFORMATION

Parent/Guardian's Name:		
Relationship to Child:		
Address:		
City:	**County:**	**Zip:**
Telephone: (H)	**Telephone: (W)**	
Telephone: (C)	**Telephone: (C)**	
Email Address:		

Please list below every person who CURRENTLY resides in your home.

Name	Age	Relationship

Is the child currently living with you right now? ☐ YES ☐ NO If no, where and who is the child living with and for how long?

CHILD'S INFORMATION

Child's Legal Name:	**Date of Birth:**
Social Security #:	**Medicaid #:**

Is the child's legal guardian a resident of Texas? ☐ YES ☐ NO

Does the Department of Family & Protective Services (DFPS) have custody of child?
☐ YES ☐ NO If yes, Level of Care:

Has the child been FORMALLY adjudicated delinquent or declared CHINS (Child in Need of Supervision)? ☐ YES ☐ NO

Has the child been on probation (formal or informal): ☐ **YES** ☐ **NO**

Dates	Charges	Probation Officer's Name & Phone Number

Please list all out of home placements (including psychiatric hospital, emergency shelter, juvenile detention, basic care facility or RTC).

Please review list of behaviors listed below and check all that apply to your child. Please describe types, frequency and dates of incidents as applicable.

✓	Behaviors	Type/Frequency/Description/Date
	Self-Injurious Behaviors	
	Suidical Ideation (thoughts)	
	Suicide Attempts	
	Running Away (overnight)	
	Visual or Auditory Hallucinations	
	Property Destruction (ie, punching holes in walls , breaking personal items, etc)	
	Verbal threats of violence	
	Law enforcment involvement (juvenile)	
	Fire setting	
	Cruelty to animals	
	Physical aggression towards a person. (assaultive behavior, if so against whom?)	

	Homicidal Ideation	
	Truancy	
	Suspeneded or expelled from School	
	Non-compliance with medication	
	Substance abuse/usage (tobacco, alcohol, illegal drugs, etc)	
	Sexualized behaviors	
	Currently sexually active	
	Defiant against authority	
	Poor impulse control	
	Bullying others (family members, peers)	
	Victim of bullying	
	Nightmares or night terrors	
	Please describe any other behaviors not listed above that necessitates placement in residential treatment:	

MEDICAL HISTORY

Please complete as part of Admission packet. This history will aid your physician in obtaining complete & detailed medical information for your record.

Current Diagnosis:

Describe any diagnosed MEDICAL conditions.

Current Medications:	**Dosages:**

Medication Allergies:

Food Allergies:

Other Allergies:

***PAST HISTORY* – Any diseases or problems with:**

Eyes:	**Heart:**
Ear,Nose,Throat:	**Stomach or Intestines:**
Lung/Respiratory:	**Kidneys:**
Muscle/Bone:	**Convulsions/Epilepsy:**

Childhood Illnesses: (Measles, mumps, chicken pox, etc.) Please include dates & ages

Past Hospitalizations (Age or date) – other than psychiatric

Operations:

Serious Injuries:

Poisonings:

Does your child have Diabetes? ☐ YES ☐ NO
****If YES, answer the following questions. ** If NO, skip down to PREGNANCY HISTORY.**
What brand and type of insulin does your child take? (short acting & long term)
How much insulin does your child take? (at meals and as needed for high blood sugar)
Does your child use a sliding scale of insulin? ☐ YES ☐ NO
What is your child's daily calorie intake? (Please include how many carbs with meals & snacks & how many snacks per day.)
Calorie Intake Carbs Meal
What was your child's last A1C and the date it was done?
What is your child's average blood sugar count?
Has your child ever been in DKA (diabetic ketoacidosis)? ☐ YES ☐ NO If yes, give date:

PREGNANCY HISTORY

Length of Pregnancy: **Adopted: ☐ YES ☐ NO**

Did mother have:	**Yes**	**What Month**	**Type or Reason**
Infections			
Bleeding			
Medications			
Injuries			
Exposure to x-ray			
Drugs/Tobacco/Alcohol			

DELIVERY HISTORY

Forceps Used: ☐ **YES** ☐ **NO** **Cesarean Section: (Reason)**

Any problems with bleeding? **Delay in cry or breathing?**

Was baby given oxygen (how long?): **Birth Weight:**

Other problems:

DEVELOPMENTAL HISTORY

(Indicate age)

Rolled Over: **Sitting:** **Walking:** **Talking:**

Using Sentences: **Toilet Trained:**

Average grades in school: **Any grades failed:** **Current grade level:**

Problems with Speech: **Vision:** **Hearing:**

Have menstrual periods begun? ☐ **YES** ☐ **NO** **What age:**

IMMUNIZATIONS: A copy of all immunization records must be attached. (include date immunization was administered).

DPT	Polio	Hep B	MMR	Varicella	TB Skin Tests
					If test was positive what treatment was provided:

Is there a history of any tobacco use? ☐**YES** ☐**NO** **How much daily?**

Is there a history of drug or inhalant use? ☐**YES** ☐**NO**
What type? **How Often?**

Is there any history of sexual abuse? ☐**YES** ☐**NO**
What age? **By Whom?**

Is there unusual exposure to any toxins such as spray, insecticides, and fumes? ☐**YES** ☐**NO**

Has client or family member traveled outside of the country (If yes, where and when)?

Does client wear glasses or contacts lenses? ☐**YES** ☐**NO**

Does client have any other prosthetic devices (hearing aids, braces, splints)?

☐**YES** ☐**NO** **Other:**

FAMILY HISTORY

Father's occupation: **Mother's occupation:**

Are parents separated or divorced? ☐**YES** ☐**NO** **Remarried?** ☐**YES** ☐**NO**

Client is in the custody of: ☐**Parent** ☐**DFPS** **Other: (please specify)**

	AGE	ANY MEDICAL PROBLEMS?
Child's Father		
Mother		
Brothers		
Sisters		

Do any biological relatives (such as parents, grandparents, siblings, aunts, uncles, cousins) have any of the following diseases:

	YES	NO	Relation to CLIENT
Drug Abuse			
Alcohol Abuse			
Mental Illness			
Deafness			
Eye Disease			
TB			
Lung Disease			
Asthma			
Thyroid Disease			
Endocrine/Hormone Problems			
Diabetes (Type I or II?)			
Anemia			
Bleeding Problems			

Kidney Disease			
Heart Disease			
Hypertension			
History of Heart Attack/Stroke (under the age of 50)			
Birth Defects			
Cancer (Type)			
Other:			

****PLEASE SEND PERTINENT PAST *MEDICAL* RECORDS****

Signature/Title of Staff Completing Form **Date**

Signature of Parent/Guardian **Date**

SEND TO: **Laurie Mazza**
Admissions Coordinator
3501 N. 19th. Street
Waco, TX 76708
254-745-5302
254-745-5126 (FAX)
EMAIL: laurie.mazza@dshs.state.tx.us

or

Lisa Reneau
Admissions/Aftercare Assistant
3501 N. 19th. Street
Waco, TX 76708
254-745-5175
254-745-5126 (FAX)
lisa.reneau@dshs.state.tx.us

FOR INFORMATION REGARDING COSTS/FEES PLEASE CONTACT: CHRISTINA SALAZAR AT 254-745-5122 OR CORNELIA HOWARD AT 254-745-5131