Jackson-Feild
Behavioral Health Services

546 Walnut Grove Drive Jarratt, VA 23867 PH: (434) 634 – 3217 Fax: (877) 991 – 8711
Admissions@jacksonfeild.org Cell: (434) 637 – 0995

APPLICATION FOR ADMISSION

(BLACK INK ONLY)

I hereby apply for admission of this individual to Jackson-Feild Behavioral Health Services, Inc.:

Patient: Is this a readmission? Yes _____ No _____

Name: _____
Last First Middle

Gender: _____ Race/Nationality: _____

Date of Birth: _____/_____/_____ Place of Birth: _____

Present Age: ___ ___ Social Security #: _____
Years Months

Address: _____

Religious Preference: _____

Agency and/or Person Making Application on Behalf of Patient:

Name: _____ Relationship to Patient: _____

Address (Agency, if applicable):

_____
_____
_____

Telephone: _____
Emergency/After Hrs. No.
E-mail Address: _____

Legal Guardian, if not the same as above:

Name: _____

Address: _____

Home Telephone: _____ Work: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

1. **Where (with whom) is the patient currently residing?**

   Name: _____ Relationship: _____

   Address: _____

Jackson-Feild
Behavioral Health Services
546 Walnut Grove Drive Jarratt, VA 23867 PH: (434) 634 – 3217 Fax: (877) 991 – 8711
Admissions@jacksonfeild.org Cell: (434) 637 – 0995

2. **Reason(s) for current treatment intervention:** _____

_____

_____

3. **Has the patient been in any residential intervention within the last two years?** Yes _No ____

4. **List in chronological order the names of all treatment interventions received within the past two years (e.g., residential, out-patient, hospitalizations, mentoring, home-based):**

Previous Treatment Intervention(s)	Type of Facility	Dates		Successful?	
		From	To	Yes	No

Transition Type (Foster Care, Relative, Shelter, Other Out of Home)	Dates		Relationship/Connection
	From	To	
			Total # of Transitions

5. **Identify the current symptoms exhibited by the patient:**

Behavioral Symptoms

_____Physical Aggression
If Yes, date of most recent: _____
_____Verbal Aggression
If Yes, date of most recent: _____
_____Homicidal acts
_____Suicide attempts
If Yes, number of attempts: _____
If Yes, date of last attempt: _____
_____Running away
_____Ignores rules

_____Gang Affiliation
_____Stealing
_____Truancy
_____Fire starting
_____Property destruction
_____Substance Abuse
If yes, list substance (s):
_____
If yes, date of last reported use: _____

Please describe: _____
_____
_____

Jackson-Feild
Behavioral Health Services
546 Walnut Grove Drive Jarratt, VA 23867 PH: (434) 634 – 3217 Fax: (877) 991 – 8711
Admissions@jacksonfeild.org Cell: (434) 637 – 0995

Socioemotional Symptoms

_____Sad/depressed mood
_____Grief
_____Low self-esteem
_____Mood swings
_____Distractible
_____Impulsive
_____Poor concentration
_____Anxiety/constant worrying
_____Hearing/seeing things others don't
_____Non-suicidal self-harming (cutting)
_____Manipulation
_____Poor impulse control
_____Dishonesty
_____Bed wetting
_____Weight changes

Please describe: _____

Interpersonal Symptoms

_____Promiscuity
_____Inappropriate sexualized behaviors with same age peers
_____Inappropriate sexualized behaviors with younger peers
_____Inappropriate sexualized behaviors with older peers
_____Prostitution
_____Survivor of human trafficking

Please describe: _____

Significant Life Events: Has the patient experienced or is suspected to have experienced any trauma, abuse, violence, neglect, conflict, or significant loss that impacts current functioning?

_____

6. **Treatment Needs and Referring Behaviors**: What are the treatment needs and/or actual behaviors for which the patient is being referred and Jackson-Feild Behavioral Health Services that staff will need to address for discharge goals?

A. **Mental Health, Emotional and Psychological Needs:** _____

B. **Educational Needs:** _____

C. **Physical Health Needs, Including Immunizations:** _____

Jackson-Feild
Behavioral Health Services
546 Walnut Grove Drive Jarratt, VA 23867 PH: (434) 634 – 3217 Fax: (877) 991 – 8711
Admissions@jacksonfeild.org Cell: (434) 637 – 0995

D. **Religious Affiliation, and Needed Accommodations, if any:** _____

E. **Are there any special protective measures that should be enforced during patient's residential intervention?** _____

F. **Behavioral Support Needs:** _____

7. **What is the discharge plan for this patient?** _____

Target Date:_____/_____/_____

8. **What is the attitude of the parents/caregivers & the patient towards this residential intervention?** _____

9. **Describe parental involvement, if any:** _____

10. **History of Court Involvement:** _____

Please list all charges and the results/status of each, including status offenses below:

Charges	Date	Results/Current Status

Is the patient presently on probation? Yes _____ No _____ (If yes, attach probation rules)

If so, for what charge? _____

Name of Probation Officer:_____

Next Court Date: _____ Time: _____ Location: _____

Is the patient court-ordered for treatment? Yes____No ____(If yes, attach court order)

Jackson-Feild
Behavioral Health Services
546 Walnut Grove Drive Jarratt, VA 23867 PH: (434) 634 – 3217 Fax: (877) 991 – 8711
Admissions@jacksonfeild.org Cell: (434) 637 – 0995

11. Indicate any special needs concerning treatment, health and/or safety (include any restraints or constraints that the facility may have to enforce, support, or provide etc.):

_____

_____

12. Describe the patient's strengths, areas of interest, and/or supports that may help motivate the patient throughout treatment (e.g. names of people, hobbies, talents, areas of previous success, competencies or expressed interests):

1. _____
2. _____
3. _____
4. _____

13. What has worked best with this patient in the past? _____

_____

14. When has the patient been most successful? _____

_____

Medical Information

Does the patient have health insurance coverage? Yes____ No _____

Company Name:_____ Policy #: _____

Past serious illnesses or infectious diseases: _____

_____

Allergies: _____

_____

Medical problems: _____

_____

Current medication(s): _____

_____

Height:_____ Weight: _____

Date of last physical (please attach):_____
Condition: _____

Date of Last dental exam (please attach):_____
Follow-up needed: _____

Date of last psychological (please attach): _____
Condition: _____

Jackson-Feild
Behavioral Health Services
546 Walnut Grove Drive Jarratt, VA 23867 PH: (434) 634 – 3217 Fax: (877) 991 – 8711
Admissions@jacksonfeild.org Cell: (434) 637 – 0995

Date of last neurological (if applicable, please attach): _____
Condition: _____

IQ Scores
Verbal _____Performance _____ Full Scale _____ Date _____

Patient's physician:_____ Telephone: _____

Address: _____

Patient's dentist:_____ Telephone: _____

Address: _____

Family Information

MOTHER:
Full name: _____
(First) (Middle) (Last) (Maiden)
Present address: _____

Home telephone:_____ Work telephone: _____ Date of birth: _____
Marital status: _____Place of birth: _____Social Security #: _____
Religious preferences: _____
Occupation (type of work & company): _____
Monthly Salary:_____ Serious illness: _____
If deceased: Date:_____/_____/_____ Cause: _____

FATHER:
Full name: _____
(First) (Middle) (Last)
Present address: _____
Home telephone:_____ Work telephone: _____ Date of birth: _____
Marital status: _____Place of birth: _____Social Security #: _____
Religious preferences: _____
Occupation (type of work & company): _____
Monthly Salary:_____ Serious illness: _____
If deceased: Date:_____/_____/_____ Cause: _____

SIBLINGS:

Name	Sex	DOB	Address	Serious Illness?

Jackson-Feild
Behavioral Health Services
546 Walnut Grove Drive Jarratt, VA 23867 PH: (434) 634 – 3217 Fax: (877) 991 – 8711
Admissions@jacksonfeild.org Cell: (434) 637 – 0995

List other significant family members (to include persons who play a family member role and/or persons who demonstrate consistent positive support to the resident): _____

_____

Are there any persons with whom this child cannot have contact? Yes ___ No ___
(If "yes" please list names below)

Name (First and Last)	Relation / Association

Other relevant information concerning family involvement in treatment:

_____
_____
_____
_____
_____
_____

Educational Information

Name of Patient: _____

Last Public School Attended: _____
Address: _____
Phone Number: _____ Contact Person: _____
Last Date of Attendance: _____ Grade Level: _____

Has the patient attended any other specialized school? Yes_____ No _____
School Attended: _____
Address: _____
Phone Number:_____ Last Date of Attendance: _____

Scholastic performance (academic strengths, weaknesses, school behavior &goals): _____

_____
_____
_____
_____

Attendance:

Attends regularly _____ Occasionally misses school _____
Often misses school _____ Has not been attending school _____

Is this applicant identified as a special education student? Yes_____ No _____

If this patient has an IEP, please have the form on the next page signed by the parent or legal guardian. This will give us time to arrange the appropriate changes in their IEP

Jackson-Feild
Behavioral Health Services

546 Walnut Grove Drive Jarratt, VA 23867 PH: (434) 634 – 3217 Fax: (877) 991 – 8711
Admissions@jacksonfeild.org Cell: (434) 637 – 0995

CONSENT FORM FOR TRANSFER STUDENT

Educational Services

As part of_____'s residential intervention at Jackson-Feild Behavioral Health Services, we would like to provide the most effective educational program we possibly can. In our goal to continue and/or develop an educational program which will best facilitate this student's General or Special Education success, we would like your consent for the following:

A. To use his/her current IEP until we can meet to make the appropriate changes consistent with his/her present residential intervention (a meeting will be scheduled within the first five (5) days of placement).

B. To consider the option of obtaining a General Education Diploma.

C. To administer educational assessments in order to determine academic functioning and progress.

I give my consent for the aforementioned actions of Gwaltney School.

_____ _____
Parent/Guardian Date

Along with this completed application please be sure to include the items spelled out on the "documentation required" form. Please do not omit any questions on this application. If you do not know the answer please state that accordingly, or put "n/a" where applicable. Please take the time to include dates where applicable as well.

Thank you so much for entrusting Jackson-Feild Behavioral Health Services in meeting this child's psychiatric needs.

Person/Agency Authorized to Place Applicant: _____

If agency, name and title of authorized agent: _____

Application submitted by:_____ Date: _____

_____ _____
Signature Date