Nexus-Gerard
FAMILY HEALING

Check which service is being requested:

☐ Long-Term Treatment ☐ Short-Term Treatment ☐ 45-Day Assessment ☐ CIBS Program

Date of Referral:_____ Referral Source:_____

YOUTH INFORMATION

Youth's Full Name:_____

Date of Birth:_____ Birth Place:_____

Gender:_____ Nickname:_____

Race:_____ HT:_____ WT:_____

Religion:_____ Hair Color:_____ Eye Color:_____

# of Siblings:_____ Preferred Pronouns:_____

Youth's Current Placement:_____

_____

Previous Placements (location & dates):_____

_____

Youth's Primary Reasons for Needing Placement:_____

_____

_____

Psychiatric Diagnosis:_____

_____

Date of Last Diagnostic Assessment:_____

Current CASII Score:_____

Current Medications:_____

_____

Medical Diagnosis:_____

Allergies:_____

Food Restrictions: _____

Physical Disabilities:_____

Family Doctor:_____

Clinic:_____ Phone:_____

Current Grade:_____ Last Known IQ:_____ IEP: Yes☐ NO☐

School District Name & Number:_____

Contact:_____ Phone:_____

Referring Agency Information

Referral Agent:_____

Agency Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone:_____ Work Cell:_____ Fax:_____

Email:_____

County Case Management Information

County Case Agent:_____

Agent Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone:_____ Work Cell:_____ Fax:_____

Email:_____

Family Information

Guardian 1:_____ Level of Involvement:_____

Relationship To Youth:_____

Check any of the following boxes that apply:

Biological: ☐ Adopted: ☐ Foster:☐ Ward:☐ Transfer of Custody: ☐

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

DOB:_____

Guardian 2:_____ Level of Involvement:_____

Relationship to Youth: _____

Check any of the following boxes that apply:

Biological: ☐ Adopted: ☐ Foster:☐ Ward:☐ Transfer of Custody: ☐

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

DOB:_____

Funding Information

Funding Agency:_____

Insurance:_____ 3rd Path:_____ PMAP:_____

MA:_____ MA number:_____

Name of Insurance Company:_____ Phone:_____

Group#:_____ ID:_____ Name & DOB of Insured:_____

Relationship to Youth:_____

Signature: _____

Thank you for completing this admissions form. Please return this form along with the following documentation to Vada Dahl, Admissions Supervisor, at email: vdahl@nexusgerard.org or fax: (507) 433-7868.

- **Diagnostic Assessment**
- **Psychological Evaluation (most recent if more than one)**
- **Psychiatric Evaluation (most recent if more than one)**
- **Developmental/Social History**
- **Discharge Summaries from previous placements (only most recent 3)**

- **Progress Reports (current placements)**
- **County Placement Agreement (if applicable)**
- **CASII**
- **Individual Education Plan (IEP)**
- **Most recent school evaluations**