Helton House, Inc.
Initial Referral Form/Assessment
(434) 392-9276

Full Name:____Identifying Number:_____________________

All blanks must be filled in. Use "None," "Unknown," or "NA" for Not Applicable.

Identifying Information

Full Name:____Male ( ) Female ( )

Last Address:____

___________________ _____________________ _____________________ ______________________
Date of Birth County of Origin Telephone Number Social Security #

Optional: ( ) White ( ) Black ( ) American Indian/Alaskan ( ) Asian/Pacific Islander
( ) Other:____

Current Address:____

Emergency Contact:____
Name Address

____
Telephone Relationship

Legal Guardian:____
Name Address

____
Telephone Relationship

Please give current directions to the Individual's residence:____

____

____

____

____

____

____

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Financial Information:

- SSI Monthly Amount: $____
- SSA Monthly Amount: $____
- SSDI Monthly Amount: $____
- Other (Please List): $____
- Medicaid Number:____
- Medicare Number:____

Criminal Justice Status:____

Medical Information:

- AXIS I: ____PRIMARY:___________________________
- AXIS II: ____PRIMARY:___________________________
- AXIS III: ____PRIMARY:___________________________
- AXIS IV: ____
- AXIS V: ____

Current GAF:____

- List serious illnesses and/or chronic conditions of parents and siblings (if known):_________________
____
____
____

Please check all that apply:

Orthopedic Devices:

- ( ) Wheelchair ( ) Braces ( ) Helmet ( ) Walker ( ) Toilet Chair ( ) Shower Chair
( ) Other (Please specify):____

Speech:

- ( ) Speech Understandable ( ) Sign Language ( ) Non-Verbal ( ) Computer Communication Board
( ) Other (Please specify):____

Physical Handicaps:

- ( ) Wears Glasses ( ) Legally Blind ( ) Tunnel Vision ( ) Hearing Aid ( ) Hearing Loss

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List past serious illnesses, infectious diseases, serious injuries, and non-psychiatric hospitalizations: ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________
List past Psychiatric Hospitalizations (List Precipitating Factors): ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ****(Please attach results of all Psychological, Psychiatric, and Neurological Exams)****
Does the individual have spells such as seizures, convulsions with high temperatures, fainting spells or staring spells? If so, describe and make a note of special instructions to be followed in the event that this happens. ____________________ ____________________ ____________________ ____________________ ____________________ ____________________
Are there any special diets required? If so, please explain. ____________________ ____________________ ____________________ ____________________ ____________________
Please list all Known allergies and adverse reactions: ____________________ ____________________ ____________________ ____________________ ____________________

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Is there a substance abuse history? If so, please explain. ( ) Yes ( ) No

____
____
____
____

Current Medications:

Date Prescribed	Mecication	Strength	Dose	Route	Schedule	Physician

Current Physician(s): Please list name(s), address(es), and telephone number(s):

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List any current and past behavior issues.

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List any past experiences with vocational and educational placements.

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Describe family/friend(s) relationships. Include family/friend(s) contact.
____
____
____
____
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____
____

What is the Onset/Duration of Individual's problems?
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____

Please check which areas there is a need for service:

( ) Residential ( ) Day Support ( ) Physical Health ( ) Money Management
( ) Transporation ( ) Medication ( ) Vocational Training
( ) Other:____

What is the reason for the referral?
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Signature of Referral Source Date

Full Name:____Identifying Number:_________________

For Helton House Inc. Use Only

Was Individual Accepted?

- Yes
- No
- Placed on Waiting List   Date:_______________________________________

Rational:

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____
Signature of Program Reviewer   Date