Updated: 1.12.24

Today's Date:

Date Placement Needed By:

Individual Completing Request:

Position:

Red River Valley Juvenile Center

600 Bruce Street
Crookston, MN 56716

Telephone: 218.470.8323
Fax: 218.281.0453

Placement Referral

All information contained in this placement referral is strictly confidential. Please fax or mail to ensure continued confidentiality.

Youth Name: *(First, Middle, Last)* ☐ M ☐ F	**DOB:**	**Age:**
Type of Referral: ☐ Secure Programming ☐ Secure Evaluation ☐ Secure Hold ☐ Residential Programming ☐ Residential Evaluation ☐ Residential CHIPS/Hold		
Youth S.S. Number:	**Race:**	
Youth's Current Residence:		

Referring Agency/Individual		
Referral Agency:		
Referral Representative:	☐ SW County	☐ Parent/Guardian:
	☐ PO County	☐ Other:
	☐ SW Tribe	

Referral Contact Information	
Direct Line:	Mailing Address:
Cell:	Email Address:
Fax:	

Type of Placement: ☐ Court Order ☐ Social Service ☐ Voluntary ☐ Other:

A copy of the hold/placement agreement will be required upon placement.

Cultural/Ethnic/Gender Identification	
Primary Language:	Secondary Language:

Youth's sexual preference: ☐ Heterosexual ☐Gay ☐ Lesbian ☐ Bi-sexual ☐ Transgender ☐ Intersex ☐ Gender non-conforming

Assets/Strengths

☐ Employment ☐ School ☐ Positive family relationships ☐ Positive peers ☐ Structured activities

Comments:

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Identified Risk Factors				
☐ Anti-social peers ☐ Anti-social attitudes/beliefs ☐ Anti-social thinking ☐ Chemical dependency ☐ Recreational/leisure activities				
☐ Family relationships ☐ Education ☐ Employment				
Family Information				
Father	BIO/Step/Adoptive	Address:	DOB	Has Custody ☐
Full Name:	Home Phone:	Cell Phone:		
Mother	BIO/Step/Adoptive	Address:	DOB	Has Custody ☐
Full Name:	Home Phone:	Cell Phone:		
Siblings	☐ M ☐ F	Name:	DOB	Contact Restrictions: Describe in Referral Source Narrative
	☐ M ☐ F	Name:	DOB	Contact Restrictions: Describe in Referral Source Narrative
	☐ M ☐ F	Name:	DOB	Contact Restrictions: Describe in Referral Source Narrative
	☐ M ☐ F	Name:	DOB	Contact Restrictions: Describe in Referral Source Narrative
Are there any restrictions on either parent's involvement? If so, please indicate here:				

Referral Source Narrative
Description:

Objectives/Expected Outcomes for Your Client
Description:

Youth's Previous Placements		
Year	Reason	Agency / Location

Youth's Previous Offenses		
Year	Offense (also explain the original charges if you are on probation)	Outcome

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Youth's Prescription & Over-the-Counter Medications			
Name of Current Pharmacy:	Pharmacy Phone Number:		
Name of Drug	Strength / Mg	Frequency Taken	Name of Prescriber & Clinic Associated With

Allergies	
To	Reaction

History: Abuse, Risk of Harm to Self/Others, Chemical Use, Physical & Mental Health, Education & Assessments						
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.						
Abuse History	☐ Neglect Perpetrator(s):					
	☐ Physical Perpetrator(s):					
	☐ Emotional/Psychological Perpetrator(s):					
	☐ Sexual Perpetrator(s):					
FASD	☐ None	☐ Suspected	☐ Requesting Diagnosis	☐ Has Diagnosis		
	If diagnosed, name of Diagnostic Clinic/Professional?					
Risk of Harm to Others	History of Sexual Behaviors or Talk?				☐ Yes	☐ No
	If yes, please describe?					
	Has the youth successfully completed treatment to address the behaviors/talk?					
	History of cruelty to animals?				☐ Yes	☐ No
	Verbally abusive to others?				☐ Yes	☐ No
	Physically abusive to others?				☐ Yes	☐ No
	Gang involvement?				☐ Yes	☐ No
	Difficulties with peer relationships?				☐ Yes	☐ No
Run Risk	History of running away?				☐ Yes	☐ No
	☐ Recent – time gone:	☐ months ago:	☐ years ago:	☐ N/A		
	# of runs:	Places youth goes:				
Homelessness	Does the youth have a history of being homeless?				☐ Yes	☐ No
Drugs / Alcohol	Does youth currently use recreational or street drugs?				☐ Yes	☐ No
	Does youth currently use alcohol?				☐ Yes	☐ No
Mental Health	Does youth have aggression tendencies or pose threats (physical or verbal)?				☐ Yes	☐ No
	Does youth have emotional outbursts?				☐ Yes	☐ No
	Does youth have any disorders? (E.g. ADHD, EBD, eating disorders, depression, anxiety, etc.)				☐ Yes	☐ No
	Is there a history of cutting or self-injurious behavior (SIB)?				☐ Yes	☐ No
	Is there a history of suicidal ideation?				☐ Yes	☐ No
	Number of suicide attempts? Current risk of suicide: ☐ High ☐ Medium ☐ Low					
	Does the youth have grief or loss suffering/issues?				☐ Yes	☐ No
	If so, describe loss and month/season it occurred:					

	Does the youth have difficulty with parental relationships?	☐ Yes	☐ No
Physical Health	Primary Physician: Phone #:		
	Clinic Name & Address:		
	Current medical concerns:		
	Chronic illnesses:		
	Dental concerns:		
	Pregnant: If so, comments:	☐ Yes	☐ No
Additional Questions	Does the youth have identity issues?	☐ Yes	☐ No
	Enuresis or Encopresis history/current concern?	☐ Yes	☐ No
	Does the youth have vision or hearing loss?	☐ Yes	☐ No
	Does the youth have history of gang involvement?	☐ Yes	☐ No
	Does the youth have a mental, physical or developmental/cognitive disability?	☐ Yes	☐ No
Education History	School Dates Attended IEP?	☐ Yes	☐ No
	School Dates Attended IEP?	☐ Yes	☐ No
	School Dates Attended IEP?	☐ Yes	☐ No
	School Dates Attended IEP?	☐ Yes	☐ No

Assessments

Are there current diagnostics/functional assessments? ☐ Yes ☐ No (If yes, please comment below)

Date:
Type of Assessment:
Clinic/Doctor:

Date:
Type of Assessment:
Clinic/Doctor:

Insurance

Name of Primary Insurance:

Address of Insurance: Telephone number:

Name of Insured: Relationship to Youth: Insured DOB:

Insured ID Number: Group Number: Name of Insured Employer:

Requested Additional Service

Additional services requested. Specific information can be added in the space provided.

☐ Psychological Diagnostic:	☐ Family Assessment:	☐ Medication Management:
☐ Psychiatric Diagnostic:	☐ Individual Therapy:	☐ Specific Medical/Dental Care:
☐ Rule 25 and/or CD Care:	☐ Family Therapy:	☐ Other:
☐ CTSS/MHBA:	☐ Community Service Hours:	☐ Religious / Cultural Needs:

Screening(s) completed by Probation or Social Services for Placement must be attached:
(Assessments completed in the last six (6) months YLS, JSOAP II, Erasor 2.0, Adverse Childhood Experience)

Please return this completed Placement Referral to both Caseworker Holly Messelt & Program Director Kyle Allen at the emails below:

holly.messelt@co.polk.mn.us kyle.allen@co.polk.mn.us

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The following will be completed by the RRVJC:

RRVJC Placement Referral Review

The RRVJC has access to programs and services, internally and in collaboration with outside agencies, which appear capable of meeting the cultural, emotional, educational, mental health and physical needs of the adolescent.

☐ Yes ☐ No

This referral for services is:

☐ Accepted

☐ Denied

Comments:

_____ _____

Program Director's Signature Date