De Paul Treatment Centers
CREATING FREEDOM

De Paul Treatment Centers
4310 NE Killingsworth St.
Portland, OR 97218
Main (503) 535-1151
Email Kellie.Fellen@depaultc.org

Youth Residential Referral Form

Fill out the form and fax to 503-535-1163 put "Attention Youth Admissions", please also fax most recent drug and alcohol assessment, mental health assessment and updated med-list (if applicable) to that fax number as well.

Any questions contact Kellie Fellen at Kellie.Fellen@depaultc.org or 503-535-1164.

General Information

Appointment date/time: _____

Date: _____ **Form completed by:** _____

Patient First Name: _____ **MI:** ____ **Last Name:** _____

DOB: _____ **Age:** _____ **SSN:** _____

Gender: ☐ Female ☐ Male ☐ Trans Female/Trans Woman/Affirmed Woman

☐ Genderqueer/Gender Non-Conforming ☐ Trans Male/Trans Man/Affirmed Man

☐ Agender/Without Gender ☐ Declined ☐ Additional Category: _____

Guardian First Name: _____ **MI:** ____ **Last Name:** _____

Guardian First Name: _____ **MI:** ____ **Last Name:** _____

Phone number(s): _____

Email: _____

Mailing address: _____

Present concerns: _____

_____

_____

Services desired: _____

Youth's SOC/level of engagement: _____

Interpretive services needed (language, hearing, other)? ☐ Yes ☐ No Specify: _____

Referent Name: _____

Referent Occupation: _____

Referent Email: _____

Referent Phone: _____

Substance Use Information

Drug(s) of Choice: _____

Previous diagnosis assigned: _____

Most recent use/pos UAs: _____

Previous treatment (include dates): _____

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Mental Health Information

MH diagnosis concerns/issues:

☐ Anxiety ☐ Bipolar Disorder ☐ Borderline Personality Disorder
☐ Depression ☐ Psychosis ☐ PTSD
☐ Schizophrenia ☐ Trauma ☐ Schizoaffective Disorder
☐ Other: _____

Suicidal ideation (check any that apply): ☐ History ☐ Current ☐ Plans ☐ Attempts

Comments: _____

Self harm (check any that apply): ☐ History ☐ Current *Type*: _____

Eating disorder (check any that apply): ☐ Purging ☐ Restrictive eating ☐ Underweight

Behavioral issues/aggression: _____

Medical Information

Current Medications:

Medication Name and Indication	

Allergies? ☐ Yes ☐ No *if yes,* please list out allergies: _____

Primary doctor/clinic: _____

Most recent medical/hospital visit: _____

Medical history: _____

_____

Medical concerns/issues: _____

_____

Academic Information

Current/Previous School: _____

Grade level: _____

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Legal Information

Parole/Probation Officer name: _____ **County:** _____

Parole/Probation Officer phone: _____

Legal concerns/charges: _____

_____

Discharge Plan

Outpatient (where/who): _____

Home (where/who): _____

Insurance Information

Method of Payment: ☐ None ☐ Self-Pay ☐ Insurance: _____

Policy info (ID/Group): _____

Insurance phone number (for providers): _____

Policyholder Name: _____

Policyholder Phone: _____

Policyholder Address: _____

Policyholder DOB: _____ **Policyholder gender:** _____