To make a referral, please send the following items:

(Incomplete applications will not be considered for admission)

Referral Checklist

☐ Day Treatment Referral Form

☐ Most recent Individualized Education Plan (if applicable)

☐ Most recent Individualized Education Plan Evaluation (if applicable)

☐ Most recent Diagnostic Assessment

☐ Neuropsychological / Psychological Testing (if applicable)

Are you applying for a half-day or full-day option?

☐ half-day (child remains in current school and attends 3 hours of day treatment)

☐ full-day (child attends 3 hours of day treatment and Metro Wilder School on-site)

Send completed referral form and documentation to:

Catholic Charities Children's Day Treatment
Admissions Specialist
Office: 612-204-8252
Fax: 612-623-2110
Email: daytreatmentadmissions@cctwincities.org

Catholic Charities Children's Day Treatment

Location: 932 East 34th Street, Door 8, Minneapolis MN 55407

Mailing Address: 1007 E. 14th Street, Minneapolis MN 55404

CATHOLIC CHARITIES
Twin Cities

DAY TREATMENT REFERRAL FORM

CHILD INFORMATION			
First Name:	Middle Name:		Last Name:
Preferred Name:			
Date of Birth:	Age:	Sex:	Gender Identity:
Ethnicity:	Language(s) Spoken:		
Address:			

REFERRAL SOURCE INFORMATION				
Referral Source: ☐Caregiver	☐School	☐County	☐Hospital/ Partial	☐Residential Tx
☐Other: _____				
Name of Referral Source:				
Agency/School				
Work Phone:	Cell Phone:			
Fax:	Email:			

PARENT(S)/LEGAL GUARDIAN(S) INFORMATION		
Name:	Relationship to Child:	
Address:		
Primary Phone:	Secondary Phone:	Email:
Name:	Relationship to Child:	
Address:		
Primary Phone:	Secondary Phone:	Email:
Name:	Relationship to Child:	
Address:		
Primary Phone:	Secondary Phone:	Email:

CUSTODY
Who has legal custody of the child?:
Who has physical custody of the child?:
Are there any limits on parental involvement? ☐Yes ☐No
If yes, please indicate:

☐I have provided a copy of custody paperwork/court order(s)
☐N/A

FAMILY HISTORY
Please provide a brief history of family involvement:

CATHOLIC CHARITIES
Twin Cities

DAY TREATMENT REFERRAL FORM

COUNTY INFORMATION			
Child's Mental Health Case Manager: County: Address: Email:		Office: Fax:	Cell:
Child Protection Case Manager: County: Address: Email:		Office: Fax:	Cell:
Guardian ad Litem: Address: Email:		Office: Fax:	Cell:

INSURANCE INFORMATION			
Primary Health Insurance Company:			
Subscriber Name:		Subscriber Date of Birth:	
Policy or ID #:	Group #:	Phone:	
Secondary Health Insurance Company:			
Subscriber Name:		Subscriber Date of Birth:	
Policy or ID #:	Group #:	Phone:	

☐I have provided a copy of all insurance cards

STRENGTHS
Please provide a description of the child's strengths. What do you think the child is good at?

CURRENT CONCERNS
Why are you currently seeking day treatment for this child?

CLINCIAL INFORMATION
Please list the child's current mental health diagnoses.

☐I have provided a copy of the most recent Diagnostic Assessment

☐N/A

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DAY TREATMENT REFERRAL FORM

EDUCATIONAL INFORMATION					
Current School:					District:
Address:					Phone:
Grade:					Fax:
Individualized Education Plan (IEP)	☐Yes	☐ No	If yes, please attach a copy		
Federal Setting (circle one)	01	02	03	04	Other:
Primary Diagnosis:		Secondary Diagnosis:			
Does the child require child-specific adult support?	☐Yes	☐ No			
If yes, please describe:					

☐I have provided a copy of the Individualized Educational Plan
☐ I have provided a copy of the ndividualized Education Plan Evaluation

LEGAL HISTORY	
Does child have a history of legal charges?	☐Yes ☐No
If yes, please describe:	
Is child currently on probation?	☐Yes ☐No
If yes, please describe:	
Has the child ever been on probation?	☐Yes ☐No
If yes, please describe:	

COGNITIVE FUNCTIONING
Full Scale IQ:
Do you feel your child is functioning: ☐ Below grade level ☐ At grade level ☐Above grade level
Is there any additional information that you would like to share about the child's cognitive functioning?

☐I have provided a copy of testing related to cognitive functioning (i.e. Neuropsychological Evaluation)
☐N/A

TREATMENT HISTORY				
Please check the appropriate setting for each provider. List most recent first.				
☐Outpatient Services	☐Inpatient	☐Residential Treatment	☐Day Treatment	☐Partial Hospitalization
Provider Name:		Agency:		
Primary Phone:		Dates of Service:		
☐Outpatient Services	☐Inpatient	☐Residential Treatment	☐Day Treatment	☐Partial Hospitalization
Provider Name:		Agency:		
Primary Phone:		Dates of Service:		
☐Outpatient Services	☐Inpatient	☐Residential Treatment	☐Day Treatment	☐Partial Hospitalization
Provider Name:		Agency:		
Primary Phone:		Dates of Service:		
☐Outpatient Services	☐Inpatient	☐Residential Treatment	☐Day Treatment	☐Partial Hospitalization
Provider Name:		Agency:		
Primary Phone:		Dates of Service:		

CURRENT MEDICATIONS			
Medication: Reason:	Dosage:	Route:	Time of Day:
Medication: Reason:	Dosage:	Route:	Time of Day:
Medication: Reason:	Dosage:	Route:	Time of Day:
Medication: Reason:	Dosage:	Route:	Time of Day:
Current Medication Prescriber:		Clinic/Hospital:	
Address:		Office #:	
Email:		Fax:	

MEDICAL INFORMATION
Does the child have any health/medical conditions? ☐Yes ☐No
If yes, please describe:
Does the child have allergies? ☐Yes ☐No
If yes, please describe: