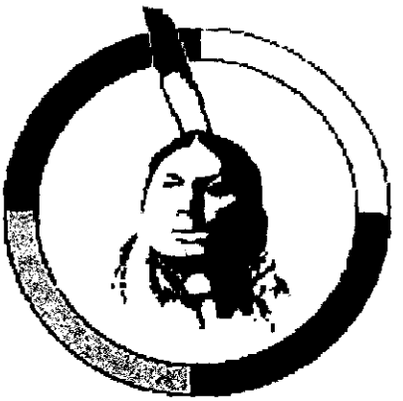
Aberdeen Area Youth Regional Treatment Center
PO Box 680
Mobridge, SD 57601-0680
(605) 845-7181
FAX: (605) 845-5072



Application Process

When submitting an application for an adolescent to enter this facility there are guidelines that must be followed before a request can be presented to the Admission Committee for consideration.

REQUIRED DOCUMENTATION

1) **Bio-psycho-social evaluation by a certified/licensed mental health professional or an Assessment with a DSM-IV diagnosis of Chemical dependency or Abuse;**

2) **Copy of Tribal Enrollment Certificate, Letter of Pending Enrollment or Proof of Lineal Descendancy;**

3) **Copy of current Physical, PPD, Immunization Record and Medical Coverage;**

4) **Authorization Form – IHS-810 (11/06) for correspondence**
   a) **To/From Parent/Legal Guardian**

These Releases need to be completed in their entirety with the appropriate boxes checked with the signature and date at the bottom. An application that doesn't have all the required fields filled in will be considered INCOMPLETE and returned to the referent for completion.

Please submit all the documents so that it can be presented to the Admission Committee for consideration in a timely manner. If you have further questions, please feel free to call (605) 845-7181 ext. 122 for Amy Yellow or fax to (605) 845-5072

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section I

Client Demographic Information

To be completed by counselor.

Client Information					
Name:					Date:
Address:			City, State & Zip Code:		
Date of Birth:	Age:	Sex:	Male Female	Social Security #:	
Home Phone:		Religion:			
Tribal Affiliation:					
Emergency Contact					
Name:			Relationship to Client:		
Address:			City, State & Zip Code:		
Home Phone #:			Work Phone #:		
Referral Source:					
Name:			Program Name:		
Address:			City, State & Zip Code:		
Phone #:			Fax #:		
Parent/Guardian Information					
Mother's Name:					
Address:			City, State & Zip Code:		
Home Phone #:			Work Phone #:		
Date of Birth:			Tribal Affiliation:		
Father's Name:					
Address:			City, State & Zip Code:		
Home Phone #:			Work Phone #:		
Date of Birth:			Tribal Affiliation:		
Health Care Coverage					
IHS Service Unit:				Phone #:	
Eligible for Contract Health Services?	YES NO	Name & Phone # of IHS/ CHS Authorizing Official:			
Medicaid (welfare)?	YES NO	Medicaid #:	State Medicaid filed in:	Eligibility Date:	

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section I

Client Demographic Information

To be completed by counselor.

Private Insurance? YES NO	Insurance #:	Name of Insured:	
Relationship to Client:		Name of Insurance Company:	
Address:		City, State & Zip Code	
Phone #		Fax #:	
Why does the client need residential treatment?			

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER
Residential Admission Form Section II
Substance Use History

Biomedical Conditions (Medical Problems and Physical Challenges):	
Allergies: Medications ____ Foods ____ Insect Stings ____ Plants ____	NOTE: Doctor statement required for allergies, bee stings and reasons for medications. Other:
Does the client have a history of: Asthma ____ Seizure Disorder ____ Heart Problems ____ Diabetes ____ Tuberculosis ____	Other medical problems:
What medications are currently prescribed for the client?	
Is the client physically challenged? Does the client use a wheelchair, crutches, cane? Does the client have vision or hearing difficulties? YES NO	If "YES", please explain:
Emotional/Behavioral Conditions and Complications:	
Has the client seen a psychiatrist, psychologist, or counselor for emotional or mental problems? YES NO	IF "YES", please explain: Therapist's Name Phone # Dates of Treatment Reason for Therapy
Is the client currently in outpatient treatment? YES NO	If "YES", describe frequency and regularity of visits:
Does the client have a history of suicide thoughts or attempts? YES NO	If "YES", please describe the situation(s) to include how and with what they tried to harm themselves:
Was the client hospitalized? YES NO	Date Methods Name of Hospital # of Days in Hospital Substance Abuse Involved? YES NO YES NO YES NO
Does the potential resident currently have any suicidal thoughts? YES NO	If "YES", please describe:
Does the potential resident currently have any homicidal thoughts? YES NO	If "YES", please describe:

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER
Residential Admission Form Section II
Substance Use History

Does the client have past or current legal problems? YES NO	If "YES", please describe:	
Does the client have a history of violent or assaultive behavior? YES NO	If "YES", please describe:	
Has the client been involved with a gang? YES NO	If "YES", which gang?	Describe the client's involvement with the gang:
	Gang colors:	
Is the client court-ordered to treatment? YES NO	If "YES", please enclose a copy of the court order.	
Does the client have any symptoms of an eating disorder? These may be restricted food intake, excessive exercise, use of laxatives, binge eating, or vomiting. YES NO	If "YES", please describe:	
Client's height (without shoes):	Client's weight (without shoes):	
Does the client have a history of firesetting? YES NO	If "YES", please describe:	
Does the client have a history of problematic sexual behavior? YES NO	If "YES", please describe:	
Does the client have a history of learning problems (learning disability, special education, resource rooms, mental retardation)? YES NO	If "YES", please describe:	
Is the client pregnant? YES NO	If "YES", how many weeks pregnant?	Who is providing prenatal care for the client?
	Location and Phone #:	When was the last prenatal appointment?
Treatment Acceptance/Resistance		
Does the adolescent recognize their use of drugs or alcohol is a problem? YES NO	Please describe:	
How do they describe their use of drugs and/or alcohol?		

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section II

Substance Use History

Relapse/Continued Use Potential:			
Is the client showing craving any drug-seeking behavior? YES NO	Has their use increased recently? YES NO	Please describe:	
Has the client made attempts to control or cut down on their substance use? YES NO		Please describe:	
If the client is *abstinent*, are they in a personal crisis and at risk of relapse? YES NO		Please describe:	

Recovery Environment

The following questions deal with whether the client's current environment is not supportive of recovery, is hazardous, or there are difficulties in the home that make it difficult to participate in treatment on an outpatient level.

	Family Member's Name	Age	Relationship
Please list the members of the client's family.			

	Name	Age	Relationship
Who currently lives in the home with the client, other than family members? Please list their names, ages, and relationship to client:			

Is there any history of violence or domestic abuse in the home? YES NO	If "YES", please describe:
Is there anyone currently living in the client's home that is an active substance abuser? YES NO	If "YES", please describe:

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER
Residential Admission Form Section II
Substance Use History

Is there anyone currently living in the client's home that is active in a program of recovery?	YES NO	If "YES", please describe:
Does the client have any friends who are non-users of active in a program of recovery?	YES NO	If "YES", please describe:
		Aftercare _____ AA/NA _____ Al-Anon _____ Alateen _____ Other _____
What type of support groups are available to the family?		Aftercare _____ AA _____ NA _____ Healing Through Feeling _____ Al-Anon _____ Alateen _____ Other _____
What are the current discharge plans for the client after treatment?		Living Situation:
		School/Work:
		Aftercare Program:
		Frequency of aftercare visits:

Additional Information

Is client's substance use at least of moderate severity?	YES	NO
Does client need an intensive program with a 24-hour structure?	YES	NO
Is client unable to control use despite active participation in less intensive care?	YES	NO
Is there a danger of physical, sexual, and/or severe emotional attached in the patient's current environment, which will make recovery unlikely without removing the individual from this environment?	YES	NO
Does the client experience difficulties in getting to outpatient treatment?	YES	NO
Has client's use increased in the last 6 months?	YES	NO

Referring Counselor's Signature: _____ Date: _____

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER

Residential Admission Form Section II

Substance Use History

Substance (check all that apply)		Age of First Use	Date of Last Use	Usual Amount Used	Frequency of Use	Months/ Years of Regular Use	How Taken (see below)	Tolerance (Yes or No)	Withdrawal (Yes or No)
Alcohol:									
Beer/Coolers									
Wine									
Hard Liquor									
Cannabis:									
Marijuana									
Hashish									
Hash Oil									
Hallucinogens:									
LSD or "Acid"									
Peyote/Mescaline									
Psilocybin									
PCP									
Mushrooms									
Datura									
Other:									
Cocaine:									
Powder									
Crack/Freebase									
Opiates:									
Heroin									
Codeine									
Opium									
Synthetics									
Stimulants:									
Speed									
Crank/Crystal									
Ice									
STP, MDA, etc.									
Sedatives:									
Valium									
Librium									
Xanax									
Nicotine:									
Cigarettes									
Cigars									
Pipes									
Chew Snuff									
Snort Snuff									
Inhalants:									
Solvents									
White-Out									
Spray Cans									
Anesthetics									

Frequency of Use:	**1 = No use in the past month**	**4 = 2-3 times per week**	**7 = Continuous use**
	2 = Once a month	**5 = Once a day**	
	3 = Once a week	**6 = 2-3 times a day**	
How Taken:	**O = Oral**	**I = Injection**	**X = Other**

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER
Residential Admission Form Section III
Medical Information

Medical		
Name of Physician:		
Address:		
Phone #:		
Date of last Physical Exam:		
Vision		
Name of Optometrist:		
Address:		
Phone #:		
Date of last Eye Exam:	Wears Contacts	Wears or needs glasses
Dental		
Name of Dentist:		
Name of Clinic:		
Address:		
Phone #:		
Date of last Dental Exam:		

Client's Signature	Date
Signature of Client's Interviewer	Date
Printed Name of Client's Interviewer/Title	Date

IHS-810 (11/06)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 11/30/2009
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:** PARENT/LEGAL GUARDIAN
NAME OF FACILITY Aberdeen Area Youth Regional Treatment Ctr	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS PO Box 680	ADDRESS
CITY/STATE Mobridge, SD 57601-0680	CITY/STATE

III. The purpose or need for this disclosure is:

☑ Further Medical Care ☑ Attorney ☑ School ☑ Research
☐ Personal Use ☑ Insurance ☑ Disability ☑ Other *(Specify)* Court(s), Legal, Educational IEP's

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Entire Record

☑ Only information related to *(specify)* All pertinent documentation regarding past and present usage history and performance in the areas listed above that apply to the treatment episode that would ensure continuity of care for this resident.

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management (Health Records) Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Enter if different from one year after date below)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PERSONAL REPRESENTATIVE *(State relationship to patient) or Witness (if signature is thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS AAYRTC PO Box 680	
CITY/STATE Mobridge, SD 57601-0680	DATE OF BIRTH

IHS-810 (11/06)
FRONT

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NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
	Aberdeen Area Youth Regional Treatment Ctr
ADDRESS	ADDRESS
	PO Box 680
CITY/STATE	CITY/STATE
	Mobridge, SD 57601-0680

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II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY Aberdeen Area Youth Regional Treatment Ctr	NAME OF PERSON/ORGANIZATION/FACILITY Standing Rock & McLaughlin IHS
ADDRESS PO Box 680	ADDRESS PO Box J
CITY/STATE Mobridge, SD 57601-0680	CITY/STATE Fort Yates, ND 58538

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NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS AAYRTC PO Box 680	
CITY/STATE Mobridge, SD 57601-0680	DATE OF BIRTH

PSC Graphic Arts (301) 443-1090 EF

IHS-810 (11/06)
FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

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NAME OF FACILITY Standing Rock & McLaughlin IHS	NAME OF PERSON/ORGANIZATION/FACILITY Aberdeen Area Youth Regional Treatment Ctr
ADDRESS PO Box J	ADDRESS PO Box 680
CITY/STATE Fort Yates, ND 58538	CITY/STATE Mobridge, SD 57601-0680

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PSC Graphic Arts (301) 443-1090 EF

ABERDEEN AREA YOUTH REGIONAL TREATMENT CENTER
HISTORY AND PHYSICAL EXAMINATION

This form is to be completed by a licensed Physician, Physician's Assistant, or a Nurse Practitioner. A complete history and physical examination **needs to be completed within at least six (6) months** prior to entering our treatment facility.

NAME: _____ DATE OF PHYSICAL: _____

DOB: _____ MALE / FEMALE (Circle one)

Vital Signs: T____ P____ R____ B/P____ HT_____ WT_____ (both without shoes)

ALLERGIES: Yes No (Circle all that apply & explain reaction:)

MEDICATIONS FOODS BEE STINGS OTHERS

VISION Screening: R_____ L_____ Corrected_____ Uncorrected_____

HEARING Screening: R_____ L_____ Corrected_____ Uncorrected_____

REPRODUCTIVE FACTORS: (circle one) G P LC SA TA	LMP:	Smoking: Y N PPD___ Chewing tobacco: Y N

Current Medical Problems: _____

Current Medications & Dose: _____

DRUG/ALCOHOL Usage History: (Circle all that apply)	Alcohol	Marijuanna	Inhalants	Prescription drugs
How long:	_____	_____	_____	_____
Last Use:	_____	_____	_____	_____
Other Street Drugs:	_____			

LABS REQUESTED: CBC SMA-7 LFT'S UA HGC TSH RPR HEPATITIS PANEL (with A, B, C) – Please Attach Copies of ALL LABS

Past Medical History: F = Family S = Self					REVIEW of Systems			Physical Examination		
Yes	No	F	S		NL	ABN		NL	ABN	Appearance
				Heart Disease			General			Skin
				Heart Murmur			Skin			Eyes
				Hypertension			Eyes			Ears
				Diabetes			Ears			Nose
				Tuberculosis			Nose			Mouth
				Asthma			Throat			Throat
				Seizures			Mouth			Neck
				Cancer			Endo/Meta			Thorax

				Hepatitis			Neuro.			Heart
				STD's			Musculo-skeletal			Abdomen
				Kidney Disease			Blood/ Lymph			Extremities
				Athlete's Foot			Cardio.			Neuro.
				Mental Disorders			Respiratory			Psych.
				Hospitalizations			GI/Liver			Genitalia
				Surgeries			Kidney/Urol			Spine/ Scoliosis
				Any Prosthesis?			Pscyh/Soc			Rectal
							Genitalia			Pelvic
							Breasts			Breast
							GYN			
							Other			

GENERAL ASSESSMENT & PLAN:
Medical Diagnosis: _____
Plan: _____
_____
Any physical restrictions? _____
(NOTE: Approximate length of stay at our treatment facility ***may*** be three months or longer depending on this resident's level of advancement. Please schedule any future CRITICAL appointments ***before*** treatment and other appointments ***after*** treatment.

**COMMENTS:

_____
_____

** PLEASE ATTACH THE PPD FORM & A COPY OF THE IMMUNIZATION RECORD:

_____
(Signature of Medical Provider & Degree)

_____
(Print Medical Provider's Name and Degree)

Name of Clinic/Facility: _____

Mailing Address: _____
Street/PO Box City State Zip+4
Phone #: ( ) _____ FAX #: ( ) _____

- Revised: 10/24/07
- IHS Manual – Chapter 18
- CARF – Section 4C

TUBERCULIN SKIN TEST QUESTIONNAIRE

Name:_____ SS#:_____ D.O.B._____

Please answer the following questions about your health prior to your TB skin test. "Yes" answers indicate conditions that can cause false results on the TB skin test.

1) Have you ever had Tuberculosis or a positive TB skin test? Yes_____ No_____

2) Are you pregnant? Yes_____ No_____

3) Are you currently ill or running a fever? Yes_____ No_____

4) Have you received a vaccine in the last two months? Yes_____ No_____
(i.e., MMR, flu vaccine)

5) Have you had a viral infection within the last two months? Yes_____ No_____

TUBERCULIN SKIN TEST DATA

*****Please note that results for a TB skin test done within the last year are acceptable, *if* all the information requested below is available on that test result.**

TB SKIN TEST MUST BE READ WITHIN 48 - 72 HOURS OF PLACEMENT ON THE FOREARM. TESTS NOT READ AND RECORDED WITHIN THIS TIME WILL BE CONSIDERED INVALID.

TB skin test given on _____ _____ on the (circle one) R / L forearm
(date) (time)

Given by:_____

Skin test read on _____ _____ _____
(date) (time) (read by)

Redness? Yes_____ No_____ Induration? Yes_____ No_____

If induration noted; size in mm's_____