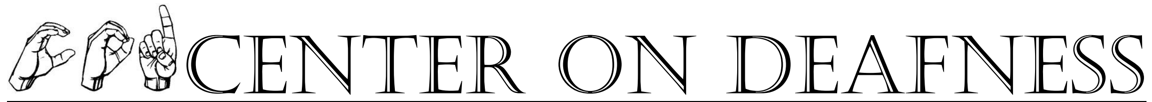

3444 Dundee Road Northbrook IL 60062 ~ 847/559-0110 TTY 847/559-9493 FAX 847/559-8199

For Office Use Only:

Date Received:	Admitted: 9 Y 9 N Admission Date:
School: 9 Day 9 Res	Assessment Date:
Referred to:	Discharge Date:

APPLICATION
CENTERVIEW THERAPEUTIC SCHOOL

IDENTIFYING INFORMATION Date:______________

APPLICANT NAME: ____ ____________
LAST FIRST MIDDLE

Address: ______________________________Phone: (___)___________

City: _________________________ County: ________________ Please Provide Photo

State: ______________________________ Zip: ___________________

Birthdate: ___/_____/______ Age: _______ Sex: _ F _ M ____________

Race: ________________________ Religion: _____________________

S.S.#: __________________ Marital Status: ___________ Military Service: _______________

Medicaid #: ___________________ Medicare #: ____

Private Insurance: ____

Primary Language/method of communication: ____

Source of Referral: ____

The Center on Deafness is dedicated to providing quality service for persons who are deaf or hard of hearing and their families, through educational, vocation, and residential services in a therapeutic, community-based environment.

Accredited by the Joint Commission on Accreditation of Healthcare Organizations
Approved by the Illinois State Board of Education

PARENT/GUARDIAN INFORMATION (CUSTODY/GUARDIANSHIP STATUS:
__Self __Mother __Father __DCFS __G&A __Other

___ PARENT ___ GUARDIAN NAME: __________________ HOME Phone:(   ) ______________

WORK Phone:(   ) ______________

Address: _________________ City: _____________ State: _______Zip: ______________________

Employer: __________________________________ Wk. Phone: (   ) ______________________

EMERGENCY CONTACTS:

Name: ___________________ Phone: (   ) _____________ Relationship: ___________________

Name: ___________________ Phone: (   ) _____________ Relationship: ___________________

REASON FOR REFERRAL AT THIS TIME
Describe and discuss behaviors or conditions that are creating significant problems in the applicant's daily functioning and psychosocial adjustment (for more room on any item, please use back of page.)

____

____

____

____

PERSONAL AND FAMILY HISTORY
Please describe the applicant's developmental/childhood/prior history and age at which emotional/behavioral problems were first identified.

____

____

____

List names and ages of parents, stepparents, and siblings. If any members of the immediate family are deceased, indicate the month and year of death. If there has been a divorce, an adoption, and/or re-marriage, please explain.

____

If there were any major events in the applicant's life that disrupted the relationship with parenting figures, please explain.

Describe the applicant's home and community environment/circumstances. Include information on usual peers and any religious/cultural group involvement.

Hobbies, personal interests, involvement in play/recreational activities.

Indicate any significant familial medical or mental health problems.

Describe the applicant's typical daily activities/schedule.

Family Involvement. Describe how family plans to be involved in applicant's treatment program (include siblings).

____

____

____

EDUCATIONAL HISTORY. (Children & adolescents only). Please attach the CASE STUDY and INDIVIDUAL EDUCATIONAL PLAN developed for school placement. Case study should include psychological evaluation, social developmental history and audiological. Please list the information requested below in chronological order.

School Name	Date Enrolled	Grade Level Completed	Special Problems	Reason for Leaving

Indicate dates and circumstances of any suspensions or expulsions from school: ______________

____

____

School district of residence: ____

District contact person and phone: ____

LANGUAGE AND COMMUNICATION:

Does the applicant rely on speech reading (lip-reading): ( ) Yes ( ) No
Rank the applicant's proficiency: ( ) Fair ( ) Good ( ) Excellent
Does the applicant use sign language? ( ) Yes ( ) No
If "Yes" rate the skill level below:

Receptive		Expressive
____________	Few Signs (single words)	____________
____________	Many signs, some finger spelling	____________
____________	Fluent	____________

Does the applicant communicate by voice? ( ) Yes ( ) No

If "Yes", describe effectiveness/problems with voice communication:

____

____

____

Comments on applicant's preferred mode of communication: ______________________________

____

Comments on applicant's acceptance of their hearing impairment: __________________________

____

Comments on other communication/language issues: ___________________________________

____

HISTORY OF MENTAL HEALTH TREATMENT

List, in chronological order, all inpatient and outpatient psychiatric treatment/counseling with diagnosis, previous placements, or participation in related community programs (if more space is needed, use the back of this page):

____

____

____

PRESENT LEVEL OF ADAPTIVE FUNCTIONING (Communication, Daily Living/Community, Interpersonal, Motor Skills). Describe applicant's strengths in these areas. (Please attach results of any adaptive functioning assessment administered to the applicant such as the Vineland Adaptive Behavior Scale, ICAP, SLOF, or other.)

____

____

____

Describe applicant's weaknesses in above functioning areas: ______________________________

____

____

____

Applicant's relationship with family members: ____

____

____

Applicant's relationship with peers; adults: ____

____

____

Applicant's attitude toward school/work:____

____

____

HISTORY OF SUBSTANCE ABUSE OR OTHER ABUSE/ENDANGERING BEHAVIOR

Has the applicant ever displayed injurious/violent behavior toward himself or others? Ever attempted suicide? Damaged property while acting out? Such incidents must be reported. Please indicate below, listing occurrences by date, and describe the particular behavior(s) and circumstances surrounding each incident.

____

____

____

____

Has applicant ever been involved in an abuse or neglect situation? _ YES _ NO
If YES, what type(s) of abuse and what was the type(s) of involvement?
(Check all that apply)

_ Emotional abuse:	_ Victim	_ Perpetrator	_ Witness
_ Physical abuse:	_ Victim	_ Perpetrator	_ Witness
_ Sexual abuse:	_ Victim	_ Perpetrator	_ Witness
_ Neglect:	_ Victim	_ Perpetrator	_ Witness

Please list abuse or neglect incidents by date and describe: ______________________________

____

____

____

Does this applicant or a family member have a history of alcohol or chemical dependency? Past/present? If so, please describe.

____

____

____

LEGAL STATUS/COURT ORDERS/PROBATION

If the client is on court ordered probation, please complete the information below:

Probation Officer: _________________________________ Phone #: ( ) _________________

Address: _____________________________ City: __________________ Zip: _____________

Reason for probation: ____

____

When does probation end? ____

Are there any other legal issues or court orders of which our staff should be aware? (Custody, pending court orders, guardianship issues, lawsuits) _____________________________________

____

PHYSICAL/PSYCHIATRIC/PSYCHOLOGICAL EXAMINATION INFORMATION (if available) Please note exam dates and provide reports of results.

Physical Exam/Medical History: ________________ If completed prior to admission:

_______ Applicant's condition is unchanged. _______ Applicant's condition changed: re-exam needed.

Electrocardiogram (EKG): ____________________ Results: ______________________________

Vision: ______________________________________Results: ______________________________

Neurological: ________________________________Results: ______________________________

Electroencephalogram (EEG): __________________Results: ______________________________

CT/MRI Scan: ________________________________Results: ______________________________

Audiological: ________________________________Degree of hearing loss:_________________

Nursing Assessment: __________________________Results:_______________________________

Immunization History:_________________________ ______________________________

_________________________ ______________________________

_________________________ ______________________________

_________________________ ______________________________

Most recent psychological and/or psychiatric evaluation (attach a copy if available):

Date: _______ Source (Name): _____________________________ Phone: __________________

Cause of hearing impairment: ______________________________ Age of onset:_____________

Does the applicant use a hearing aid? __ Yes __ No

Is the client ambulatory? __ Yes __ No

If 'No', please explain: ____

Please list any allergies (if any): ____

CURRENT MEDICATIONS (if more space is needed, use the back of this page):

Name: ___________________ Dose: _____________ Frequency: ________

Name: ___________________ Dose: _____________ Frequency: ________

Name: ___________________ Dose: _____________ Frequency: ________

RESOURCES AVAILABLE (subsidized housing, health care benefits, social services, income entitlements)

Is this applicant covered by private health insurance? __ Yes __ No

If 'Yes", please complete the information below:

Company: ______________________ Type of coverage: __ Individual __ Family

Policy #: ______________________________ Company's phone #: (   ) ____________________

Name of insured:________________________Insurer's Social Security #:____________________

Other resources available: ____

Referring Agent/Person (please print): ____

Signature of person completing the preceding sections:

____

NAME RELATIONSHIP

Please remember to attach the following documents if available:

- ☐ 1. Educational case study (students only)
- ☐ 2. Medical and psychiatric history including immunization records
- ☐ 3. TB Screening
- ☐ 4. Identifying documents including:
    - a. Birth certificate
    - b. Copy of social security card
    - c. Copy of hospitalization card or Medicare/Medicaid card
- ☐ 5. Photo (11/2 X 11/2)