WINGS Referral Form

Please complete this form to the best of your ability.
Please include if available with this form the following:
*** Chemical Health Assessment * Mental Health Assessment *Educations or IEP documents**

Please know securing a place on the WINGS waiting list on occurs upon participation in the WINGS phone screen and subsequent determination of adequate fit and perceived ability to sufficiently meet the referred client's needs.

Please FAX to 320-593-0442 or email to Info@WINGSATS.COM

Need for Residential service as soon as available? ☐ YES ☐ NO Review as a Backup plan for a lower level of care: ☐ YES ☐ NO

Client Information:

Clients name:_____ Date of Birth: _____ Contact Info (phone):_____

Sex at Birth _____ Current Sex _____ Gender Identity & Preferred Pronouns : _____

Parent/Guardian Information:

Parent/Guardian #1 Name:_____ Contact Info (phone):_____ Email:_____

Current address:_____
City/State/ZIP

Parent/Guardian #2 Name: Contact Info (phone): Email:

Current address:_____
City/State/ZIP

Does Parent/ Guardian #1 have: Physical Custody: ☐ YES ☐ NO Legal Custody: ☐ YES ☐ NO

Does Parent /guardian #2 have: Physical Custody: ☐ YES ☐ NO Legal Custody: ☐ YES ☐ NO

Referring Agency Information:

Referring Agency:_____ Agency contact number: _____

Contact Person #1 with Agency: _____ Email:_____

Contact Person #2 with Agency:_____ Email:_____

How will this client be Funded: Private Insurance / PMAP / Direct Access)

Insurance Company:_____ Policy ID:_____ Group #:_____ Medical Assistance #: _____

Involved External Care Team Members:

Probation Officer: Name_____ Phone #:_____ Email:_____

Social Worker: Name:_____ Phone #:_____ Email:_____

Rule 25 Assessor Name:_____ Phone#:_____ Email Address:_____

Other care members involved in clients treatment : Name:_____ Phone # :_____ Email:_____

Is referred client an IV user: ☐ YES ☐ NO Is referred Client Pregnant? ☐ YES ☐ NO

client willing to participate in a phone screening? ☐ YES ☐ NO ☐ Uncertain

Special Service Needs:

Will interpreter services be needed: Client ☐ Yes ☐ No Family/Guardian: ☐ Yes ☐ No

If so, what language will be needed _____

Are there any other special service that will be needed: _____

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History of referred client's participation in lower levels of care

YES: Please provide details (Completion status date of service termination) _____

_____

_____

NO: Rational for forgoing lower level of care prior to referral to residential _____

_____

Referred client history of physical aggression?

YES: Please provide details _____

_____

NO ☐

Medical needs carrying the potential to create barrier to residential treatment (physical limitations to participation in recreational activities, phobias, or unwillingness to consent to blood draw for admission physical, requirement of opioid pain relievers for current or recent injury, misc. other)

YES: Please provide details _____

_____

NO ☐

Personal belief carrying the potential to create barriers to residential treatment? (Animate resistance to residential treatment participation, unwillingness to explore medication options as needed, guardian unwillingness to cooperate or engage in support of client's residential treatment)

Yes: Please provide details _____

_____

NO ☐

Miscellaneous/other potential barriers to residential treatment? (Inactive or transitioning medical insurance, primary guardian residing out of the state of MN which causes barriers to funding of educational services provided by Meeker and Wright Special Education Cooperative -our educational provider)

Yes: Please provide details _____

_____

NO ☐

History of:

Suicidal Ideation Details: _____

Homicidal Ideation Details: _____

Self- injurious Behaviors Details: _____

Current:

Suicidal Ideation Details: _____

Homicidal Ideation Details: _____

Self- injurious Behaviors Details: _____

Current Medications and approximate initiation date (please list any medication prescribed even if client is not taking as prescribed)

Medication Name:		Date of Initiation:		Taking as Prescribed?	
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