

Wings Referral Application

Please complete this form to the best of your ability.

Please include, if available with this form the following:

* Substance Use Assessment *Mental Health Assessment *Education or IEP Documents.

Please know securing a place on the Wings waiting list occurs upon participation in the Wings phone screen and subsequent approval determination.

[Please fax to 320-316-2383 or email to Info@Wingsats.com](mailto:Info@Wingsats.com)

Client Information

Client Name

(First, Middle and last)

Preferred Name

Date of Birth

Client Current Address, City, State and Zip

Client Phone Number

Sex

Gender Identity

Preferred Pronoun

Will interpreter services be needed?

Yes

No

If so, what language

Is the client a current IV user?

Yes

No

Is the client pregnant?

Yes

No

N/A

Does the client have children?

Yes

No

Is the client willing to participate in a phone screen?

Yes

No

Present location of the child?

Present location contact information (REQUIRED)

Is the client willing to engage in educational services?

Yes

No

Urgency of Need

Funding Information

Primary Insurance

Policy ID

Group

Secondary Insurance

Policy ID

Group

MA/PMI Number

Guardian Information

Guardian #1

Relationship

Contact Phone

Email

Current Address (City, State and Zip)

Does parent/guardian have (check if applicable)

Physical custody

Sole legal custody

Joint legal custody

No custodial rights

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Guardian #2

Relationship

Contact Phone

Email

Current Address (City, State and Zip)

Does parent/guardian have? (check if applicable)

Physical Custody

Sole Legal Custody

Joint Legal Custody

No Custodial Rights

Referring Agency

Agency Name

Contact Person #1 with agency

Email

Phone and Extension

Have you referred to Wings before?

If no, how did you hear about Wings.

Contact person #2 with agency

Email

Phone and Extension

External Care Team

Social Worker

County

Phone (include extension)

Email

Probation Officer

County

Phone (include extension)

Email

Substance Use Assessor

Name

Organization

Phone (include extension)

Email

Other Care Team Member involved in client's treatment

Name

Agency

Phone (include extension)

Email

Relationship with client

Name

Agency

Phone (include extension)

Email

Relationship with client

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Treatment Accommodations

Individualized need (Check all that apply)

	Mediation Assisted Therapy (MAT) Suboxone/Sublocade		Grief/loss Counseling
	Mood Disordered Services		Disordered Eating
	Psychosis Management		Diet and Exercise Specific Services
	Treatment/Management of Chronic Medical Condition		Culturally Specific Services
	Anger Management		Other:

Dietary Restrictions:

Therapeutic Services History (List most recent first – Please list all places of care for no less than 3 years)

1. Services Provider Level of Care

Service Introduction Date

Service Termination Date

Discharge Status

2. Services Provider Level of Care

Service Introduction

Service Termination

Discharge Status

3. Services Provider Level of care

Service Introduction

Service Termination

Discharge Status

4. Services Provider Level of care

Service Introduction

Service Termination

Discharge Status

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Demonstration of medical necessity. (Please identify how less restrictive settings would be insufficient in meeting needs.)

Barriers to treatment progression (check all that apply)

<input type="checkbox"/>	Physical Limitations to Participate in Recreational Activities	<input type="checkbox"/>	Fear/Phobias
<input type="checkbox"/>	Unwillingness to Consent to Blood Draw for Admission Physical	<input type="checkbox"/>	Medical Management Apprehension, Non-compliance, or Policy Conflict, Concerns
<input type="checkbox"/>	Support System Resistance	<input type="checkbox"/>	

History of Destruction of Property?

History of Physical Aggression (if yes, please explain)

Stability – History & Current Concerns:

Medication:

Medication Name	Date of Initiation	Intended Use	Compliance (Y/N)
1.			
2.			
3.			
4.			
5.			
6.			

History of Discontinued Medication & Rational Behind Discontinuation: