

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 *Education 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 320-316-2383 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: Preferred Name Contact (phone):
Date of Birth 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 Physical Custody YES NO

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/BHF)

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

Secondary Insurance (if applicable)

Insurance Company Policy ID: Group

Involved External Care Team Members:

Probation Office 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 screen 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:

Are there any dietary restrictions:

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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? (Adamant 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

Is potential client willing to engage in educational services working toward a diploma Yes No

Miscellaneous/other potential barriers to residential treatment? (Primary parent or guardian reside out side the state of Minnesota)

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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