

# Wings Referral Application

**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 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](mailto:Info@WINGSATS.COM)

## Client Information

Client Name Preferred name  
(First, Middle and Last name)  
Client Current Address, city, state, zip  
Client phone number Date of Birth Age  
Sex Gender Identity Preferred pronoun(s)  
Is the client a current IV user Yes No Is the client pregnant Yes No Male  
Is the client willing to participate in a phone screen Yes No  
Is the client willing to engage in educational services and work toward a diploma? Yes No  
Need for residential services as soon as available? Yes No  
Review as a backup plan for a lower level of care. Yes No  
Who has custody of at time of Admission: Sole Legal Joint Custody  
additional information:

## Funding Information:

Primary Insurance Group #  
Policy ID  
Secondary Insurance Group # MA PMI  
Policy ID

## Parent Guardian Information:

Parent/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

Parent/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

**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

Agency Email

Phone and extension

**External Care Team:**

Social Worker:

County

Phone (include extension)

Email

Probation officer

County

Phone (include extension)

Email

**SUD Assessor:**

Name

Organization

Phone (include extension)

Email

**Other care members 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:

Will interpreter services be needed? Yes      No      If yes, what language will be needed

Are there any special services that will be needed?

Are there any dietary restrictions?

History of referred client's participation of lower level of care (please list all places of care and termination dates

1.

2.

3.

4.

Rational to forego to a lower level of care prior to residential:

Does client have any 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, requirements of opioid pain relivers for current or recent injury, misc. other

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Does the referred client have a history of physical aggression (if yes, please explain)

Are there any potential barriers that could interfere with residential treatment?

## History of:

Suicidal ideations – Details:

Homicidal ideations – Details

Self-injurious behaviors – Details

## Current:

Suicidal ideations – Details:

Homicidal ideations – Details

Self-injurious behaviors – Details

**Current medications and approximate initiation date (please list all medications currently prescribed even if client is not taking as prescribed)**

**1. Medication Name**

**Date of initiation**

**Taking as prescribed** Yes No

**2. Medication Name**

**Date of initiation**

**Taking as prescribed** Yes No

**3. Medication Name**

**Date of initiation**

**Taking as prescribed** Yes No