Normile Family Center
1400 South Boundary
Kirksville, MO 63501
Phone (660) 665-4224 Fax (660) 665-2890

Referral Form

*** Copy of Protective Custody authorization must accompany this form.**

Name of Person Completing Form:			
Title/Agency:		**Transporter:**	
Admission Date:		**Admission Time:**	

PERSONAL INFORMATION

Juvenile's Full Name:				**SSN#**			
Address:							
Telephone:			**Medicaid #:**				
Age:		**DOB:**		**Gender:**		**Race:**	
Height:			**Weight:**				
Mother:			**Telephone:**				
Address:							
Father:			**Telephone:**				
Address:							
Legal Guardian:		**Telephone:**					
Address:							

Emergency Contact People and Telephone Numbers:

Contact:		**Telephone No.**	
Contact:		**Telephone No.**	
Contact:		**Telephone No.**	

VISITOR INFORMATION

Approved Visitors Names:	**Phone Numbers:**

REASON FOR PLACEMENT

ESTIMATED LENGTH OF STAY

PREVIOUS HISTORY OF JUVENILE

Does the juvenile have a history of any of the following? *(Please check and explain all that apply)*

☐ Gang involvement, if so name of gang: _____

☐ Suicide threats / attempts (please circle) ☐ Assaultive behavior ☐ Alcohol / Drug Dependency

☐ Sexual offending behavior ☐ Sexual Abuse Victim

Please explain: _____

_____

_____

_____

_____

What can be expected regarding the juvenile's attitude during placement?
☐ Angry ☐ Unaffected ☐ Depressed ☐ Crying / sullen ☐ Cooperative ☐ Suicidal ideation's ☐ Hostile

MEDICAL HISTORY
Is the juvenile currently impaired by the influence of alcohol/drugs? ☐Yes ☐ No
If yes, who has deemed juvenile "Fit for Confinement"?
Physician Name: _____

Does the juvenile have any disabilities or special dietary requirements or other special needs? ☐ Yes ☐ No
Explain: _____

Medications

Medicine	Dose	Reason	Doctor

Does the juvenile have a history of any of the following?
☐ Allergies ☐ Heart trouble ☐Bedwetting ☐Sleepwalking ☐ Asthma ☐ Diabetes ☐Convulsions
☐Fainting ☐ Seizures ☐ Reaction to meds ☐Pregnancy ☐ Infectious Disease(s) (HIV, lice, Hepatitis, TB, STD)

*** List below any allergies (prescriptions, over the counter medications, food, etc.)**

Family Doctor:		**Last Visit:**		**Reason:**	
Family Dentist:		**Last Visit:**		**Reason:**	
List below any current medical/dental needs					

List Below Any Past Serious Injuries/Surgeries/Hospitalizations

List Below Any Past Counseling/Psychiatric Care (where, when, with who)

SCHOOL INFORMATION
Last school attended _____ Grade _____
Does the juvenile have an I.E.P.? ☐ Yes ☐ No
List any special education needs (BD, LD., etc.) or educational disabilities:

_____

_____

INSURANCE INFORMATION (other than Medicaid)
Policy Holder's Name _____ Relationship _____ Policy Number _____
Insurance Co _____ Address _____

*******ATTACH BIRTH CERTIFICATE, IEP AND IMMUNIZATION RECORDS********

_____ _____ _____
Signature of Referral Source Title Date

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Placement Agreement

Re: _____ (Juvenile)

S.S. No. _____ D.O.B. _____

I understand that above juvenile has been placed in the care and custody of the Normile Family Center, Second Judicial Circuit. While at the Normile Family Center the child may participate in an assessment process including any of the following: medical examination, alcohol and drug evaluation, social history assessment, psychological evaluation or psychiatric evaluation.

I authorize the staff of the Normile Family Center to seek and obtain any medical, dental, psychological or educational services seen as necessary to benefit the child. Furthermore, I authorize the Normile Family Center to obtain full and accurate social, psychiatric, medical and school information regarding said juvenile and any family information that might be helpful in providing services. I further authorize the Normile Family Center to release information regarding said individual to other agencies that may provide services to the juvenile. I release any firm, physician, clinic, hospital, agency or school district from any liability for information furnished pursuant to this authorization.

I authorize the Normile Family Center to provide non-prescription medication (s) as needed for ailments such as headaches, fever, stomach cramping, sinus congestions, or upset stomach and obtain any and all medical/dental treatment as needed.

I give permission for said juvenile to participate in any field trip that he/she may be eligible for, some of which may be in a surrounding state. I realize that any activity that takes place away from the controlled environment of the Normile Family Center may present a higher risk of injury to my child. The Normile Family Center staff shall take every precaution to safeguard the welfare of your child(ren) but cannot be held responsible in the event of accidents or injuries occurring on field trips where reasonable precautions were taken to ensure the child's safety. I further give permission for said juvenile to participate in a Equine Assisted Education Program through the Kirksville R-3 Schools which part takes place on the Truman Farm, located south of the Normile Family Center.

I understand that the Normile Family Center is a non secured facility.

_____ _____
(Signature of Parent Legal guardian) (Date)

_____ _____
(Witness) (Date)

NORMILE FAMILY CENTER
1400 South Boundary Street
Kirksville, MO 63501

Garla L. Mills, B.S.
Director of Residential Services

Phone 660-665-4224
Fax 660-665-2890

Dear Referral Source:

At the Normile Family Center, our goal is to provide a positive and safe environment for youth in our care. Direct care staff are trained in Safe Crisis Management services which handle any behaviors of concern that may arise while your youth is with us. Staff will use the least restrictive means necessary to help residents regain control of themselves should an incident occur. Staff receives extensive training in a number of different de-escalation techniques to ensure everyone's safety.

Direct care staff also receives extensive training in the use of emergency physical intervention techniques should they become absolutely necessary. These types of interventions are used only as a last resort in an attempt to help a resident regain control of their behavior, and keep all parties safe. If such an incident arises, you will be notified. If you have any questions regarding these policies, please feel free to contact me at 660-665-4224.

Sincerely,

Jamie Kethe
Normile Family Center Safe Crisis Management Instructor

_____ _____

Referral Source Witness

Revised 1/13-gm

Missouri Department of
SOCIAL SERVICES
Your Potential. Our Support.

JEREMIAH W. (JAY) NIXON, GOVERNOR • BRIAN KIKNKADE, INTERIM DIRECTOR

CANDACE A. SHIVELY, DIRECTOR
CHILDREN'S DIVISION
P.O. BOX 88 • JEFFERSON CITY, MO 65103-0088
WWW.DSS.MO.GOV • 573-522-8024 • 573-526-3971 FAX

Written Placement Agreement for Residential Care

Child: _____
Date of Birth: _____

TO WHOM IT MAY CONCERN:

The residential treatment facility is authorized to enroll children in school, to seek emergency and routine medical care, and to give authorization for treatment. This authorization does not extend to surgical procedures or procedures requiring general anesthesia. In the event of a medical emergency requiring surgery or any procedure requiring general anesthesia, please immediately contact the worker, supervisor, or call the hotline at 1-800-392-3738 and ask for the on call worker.

If you have any questions, please feel free to contact the worker or supervisor.

_____
Case Manager/Service Worker

Telephone: _____

_____
Supervisor

Telephone: _____

Date: _____