GUARDIAN ANGEL HEALTHCARE, LLC
PRE- ADMISSION FORM

Member's Name ____________________________ Date of Referral_____________

I. Source of Referral: check one

- ❑ Mental Health Agency____
- ❑ Hospital____
- ❑ DSS____
- ❑ Parent/Guardian____
- ❑ Other (specify)____

Person making referral_________________________Phone___________________
Address____

II. (a) Reason for Referral: check all that apply

______Academic/Developmental delays _____Behavior problems at home
______Behavior problems _____Behavior problems in community
______Emotional/Social problems _____Juvenile delinquency
______Physical aggression _____Physical problems
______Psychomatic _____Physical abuse
______Runaway/ Elopement _____Truancy
______Sexual abuse (victim/perpetrator) ______Self-Abusive
______Suicidal _____Substance Abuse (Drugs/Alcohol)
______Verbally aggressive _____Withdrawn
Other reason: ____

(b) Significant Life Events/Out of Home Placement(s) (number of) ___________

Services Category: ____Community Housing ____Community Integration
____Supported Employment

Service Type(s) and Billing Codes: _____________________________________
____
____
____

III. Family Information:
Mother's name____
Father's name____
Consumer lives with: ____Mother___ father____ Other____________________________

Legal guardian____

Address_____________________________________Zip___________County_________
Phone Number (daytime) ______________________(evening)_____________________

Other emergency contacts: Name: ____

Address____ Zip___________
County______________________________

Phone number (daytime) ____________________(evening)_______________________

Member's Summary

Record# if applicable_____________________

Medicaid #_____________________

Date of Birth________________ Age_____ Birthplace__________________________

Gender: Male___ Female___

Race: White____ Black___ Native American___ Hispanic____ Bi-racial________

MCO____

Please attach a copy of ID and Social Security card if admitted for services

Admitting Diagnosis: Axis I____
Axis I____
Axis II____

Community Involvement / Volunteering:

____
____
____
____

Activities/Interest/Hobbies

Music_________________________________Games___________________________

Arts/crafts_____________________________ books/puzzles______________________

Other____

Medical History: (Diagnosis)

____

____

____

____

____

Allergies:

Food___________________ ___________________ _____________________

Seasonal ________________ ___________________ _____________________

Medicine________________ __________________ _____________________

Asthma ___________ Diabetes______ Seizure_______ Other________________________

Medications___________________________for___________________________________

___________________________ __________________________________

___________________________ __________________________________

Psychotropic Medications_________________________for_______________________

_________________________ _________________________

_________________________ _________________________

_________________________ _________________________

Summary of behavior issues / past intervention strategies

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____

Summary of special diet or medical care:

Summary of Strengths:

Summary of Problems / Needs:

Summary of Likes / Dislikes

Other significant issue(s):

Valued traditions and customs of member and/or family member(s) that require recognition and or respect:

____
____
____
____
____
____
____
____
____

Special Racial, Religious, Ethnic, or Cultural Needs:

____
____
____
____
____
____
____
____
____

What foods do the member like to eat? _______________________________________

____
____

What activities do the member like? ____

____
____

Where does the member like to spend leisure time? ___________________________

____

____

What does the member like to be called? ____________________________________

What clothes do the member like to wear? _________________________________

____

____

Where does the member like to shop? _______________________________________

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