LathamCenters

Passage to a brighter future

1646 Main St. (Route 6A)
Brewster, MA 02631-1716

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(508) 896-8310 fax or
(855) 805-0609 fax (toll free)

admissions@lathamcenters.org
www.lathamcenters.org

TTY and ASCII Users: (800) 720-3840
Latham Centers is an equal opportunity provider and employer.

APPLICATION FOR ADMISSION

☐ Children's Services ☐ Adult Services

INDIVIDUAL INFORMATION

Individual:	Date of Referral:
Date of Birth:	Social Security #:
Religion:	Place of Birth:
Nationality:	Race:
Citizenship:	
Name of person making referral:	
Title:	
Reason for Referral:	
Is a social service agency(ies) involved? ☐Yes☐No	
Name:	
Address:	
Contact:	
Phone:	

Placement History (Please list all prior placements, including specialized day programs).
Does individual require any specialized equipment or accommodations?
Are there specific restrictions or needs that are important for Latham Centers to be aware of?

FAMILY INFORMATION

Parent(s):	
Mother:	Father:
Mother's Maiden Name:	
Address:	Address:
Phone:	Phone:
Fax:	Fax:
e-mail:	e-mail:
Date of Birth:	Date of Birth:
Place of Birth:	Place of Birth:
Nationality:	Nationality:
Race:	Race:
Primary Language:	Primary Language:
Home Language:	Home Language:
Legal Guardian	**Emergency Contact**
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
e-mail:	e-mail

Adoptive/Step Parent (if applicable)

Adoptive/Step Mother	Date of Birth	Place of Birth
Address	Nationality	Race
Phone	Fax	e-mail
Adoptive/Step Father	Date of Birth	Place of Birth
Address	Nationality	Race
Phone	Fax	e-mail

Siblings: Please list all siblings, date of birth, current address and indicate if half brother/sister and which parent.

Sibling	Date of Birth	Current Address	Half Brother/Sister	Which Parent

Family History: Below list the name, age, medical (history of cancer?), learning disorders/giftedness, mood disorders, postpartum depression, psychotic disorders, OCD/tics, degenerative diseases (Parkinson's, Alzheimers, etc.) education, and employment of each family member.

Name	Age	History

Recent Challenges at School and Home for student:

Current Involvement: Indicate if any of the following legal issues apply to the individual. If yes, specify.

		If Yes, Specify
DDS/Current ISP	☐Yes☐No	
Guardianship	☐Yes☐ No	
Rogers Petition	☐Yes☐ No	
DCF Involvement	☐Yes ☐No	
CHINS	☐Yes ☐No	
Arrests	☐Yes☐ No	
Probation	☐Yes☐ No	
Trusts	☐Yes☐ No	
DMH	☐Yes☐ No	
Other	☐Yes☐ No	

EDUCATION

☐**Elementary** ☐**Secondary** ☐**Post Secondary**

IQ:_____ If student, does he/she have an IEP? ☐Yes ☐No

Highest Grade Completed? _____

School District:_____ Name of School/College _____

Contact Name: _____ Address: _____

Phone: _____ Fax:_____e-mail: _____

Did individual repeat any grades? ☐Yes ☐No, If yes which ones? _____

Special Ed? ☐Yes ☐No
Date Eligible for Special Ed (if known disability, date is generally at 3rd birthday)_____

MEDICAL, SOCIAL and PSYCHIATRIC HISTORY

THE INFORMATION BELOW MUST BE COMPLETED FULLY FOR ADMISSION

Parents MUST provide Latham with all insurances including Medicaid numbers, Out-of-State Insurance, Dental Insurance, etc. Latham is NOT responsible for any co-pays.

Dental Insurance, if applicable:_____

Primary Insurance:_____ **ID #:**_____

Secondary Insurance:_____ **ID #:**_____

(Please send copy of front and back of all insurance cards. Actual insurance cards will be needed on date of intake)

Does individual wear glasses? ☐Yes ☐No

Current height: _____ Current weight:_____Hair color:_____

Eye color:_____Identifying marks (scars): _____

Allergies:

Medications:	
Foods:	
Environmental:	
Other:	

Current Medications:
(Include over the counter medications)

Current Diagnoses: Include all Medical and Psychiatric

WE ARE NOT ABLE TO ACCEPT ANY MEDICATIONS FROM HOME AS ALL OUR MEDICATIONS COME FROM THE PHARMACY USING THE MEDICATION ON TIME SYSTEM. OUR REGULATIONS REQUIRE PRESCRIPTIONS AND WRITTEN PHYSICAN ORDERS FOR ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS (INCLUDING PRN'S AND OVER THE COUNTER MEDICATIONS (vitamins, fish oils, pain relievers, creams, other supplements, c-paps etc). IF AN INDIVIDUAL COMES WITHOUT THESE IN PLACE, THEY WILL NOT BE ABLE TO RECEIVE THEIR MEDICATIONS UNTIL THE PRESCRIPTIONS ARE ACQUIRED. (If you have any questions, please notify the Admissions Department or someone from our Nursing Department).

Physicians/Health Care Professionals:	
Physician (Primary)	Last physical date and results:
	(Physical must be within last 12months)
Name:	
Address:	
Tel. No.:	
May we Contact: ☐Yes ☐No	
Physician (Psychiatric)	Last appt. date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: ☐Yes ☐No	

Dental	Last appointment date and results:
Dentist Name:	**(Dental appointment must be within last 6 months)**
Address:	
Tel. No.:	
May we Contact: ☐Yes ☐No	
Physician (Eye)	Last appointment date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: ☐Yes ☐No	
Physician (Other)	Last appointment date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: ☐Yes ☐No	
Physician (Other)	Address:
Name:	
Address:	
Tel. No.:	
May we Contact: ☐Yes ☐No	

PAST MEDICAL HISTORY:

Communicable Diseases:

Has individual ever had	Yes	No	Date
Chicken Pox	☐Yes ☐No		
Measles	☐Yes ☐No		
Mumps	☐Yes ☐No		
Rubella	☐Yes☐ No		
TB	☐Yes☐ No		

Hospitalizations/Operations:

Date	Reason	Hospital	Doctor

Please indicate past or present medical problems:

Psychiatric/Behavioral Problems

Has individual ever had or currently have any of the following problems. For any 'yes' answers, please give current status/specifics on separate page and send that with this form.

Problem	**Yes**	**No**	**Problem**	**Yes**	**No**
Agitation	☐Yes	☐No	Depression	☐Yes	☐No
Suicidal Thoughts	☐Yes	☐No	Anxiety	☐Yes	☐No
Phobias	☐Yes	☐No	Mood Swings	☐Yes	☐No
Feeling of Worthlessness	☐Yes	☐No	Rapid Cycling	☐Yes	☐No
Loss of Control	☐Yes	☐No	Nightmares	☐Yes	☐No
Nervousness	☐Yes	☐No	Night Terrors	☐Yes	☐No
Hoarding	☐Yes	☐No	Self-Injurious Behavior	☐Yes	☐No
Elopement	☐Yes	☐No	Fire Setting	☐Yes	☐No
Rumination	☐Yes	☐No	PICA	☐Yes	☐No
Picking	☐Yes	☐No	Skin ☐	Rectal☐	
Aggression	☐Yes	☐No	Verbal☐	Physical☐	

Growth and Development:

Child			
Describe strengths:			
Describe weaknesses:			
Describe how individual interacts with others in the family. With peers.			
Does the Individual exercise daily?	☐Yes☐No	For how Long:	
Does the individual Steal?	☐Yes☐No		
Is a Behavior Plan in use?	☐Yes☐No		
(If yes send a copy)			
What behavioral guidelines help the most?			
What are some of the minor aggressive actions that cannot be redirected?			
What is the most serious aggressive act?			
Where do most of the aggressions occur?			
Home ☐	School ☐	Bus☐	In Public Place☐
What coping mechanisms work for the individual?			
Is any Counseling received?	☐Yes☐No		
If Yes what type	Family ☐	Individual ☐	Group ☐

Are sensor alarms used in the house?	☐Yes ☐No
Are there alarms installed on windows and doors	☐Yes☐No
If yes, For how long?	
Reason installed	

Is a special seat belt used for transportation on a school bus or van?	☐Yes ☐No
If yes, what type	

What level of supervision is needed in the community?			
Full Supervision ☐	Some Supervision ☐	Some Independence☐	Full Independence☐

Can individual carry money?	☐Yes☐No
Can individual use public transportation independently?	☐Yes☐No
Can individual spend time alone at home?	☐Yes ☐No
If yes, How long?	
Does individual use telephone appropriately?	☐Yes☐No
If yes, How Long?	
Orders take-out food to be delivered when unsupervised?	☐Yes☐No
Does individual have any vocational or work experience?	☐Yes☐No
If yes, describe:	
Does individual use a computer?	☐Yes☐No
Describe level of their ability	

FILL THIS SECTION OUT IF INDIVIDUAL HAS PRADER-WILLI SYNDROME

Date of PWS diagnosis:	
Diagnosis made by whom:	
What are the genetic findings (deletion, disomy, mylation defect)?	

Please provide copies of genetic testing to Latham.

What has been the course of medical treatment for PWS (include dates started):					
-growth hormone?					
-Thyroid hormone?					
-Estrogen/testosterone replacement?					
At what age did the child begin to over eat?					
Highest individual ever weighed			Weight today		
Has individual been given a goal weight?					
Is their Diet:	Structured ☐	Calories counted ☐	Eats what family eats ☐		
Describe how individual acts in public where food is available.					
Does the individual food seek?			☐Yes☐No		
If yes:	in the neighborhood☐	Garbage☐	School ☐	Work ☐	Home ☐

Sweeteners	Limited☐	Unlimited☐	How many used daily?	
Does the individual drink water?	☐Yes☐No		How many glasses a day?	

How many calories consumed in a day?	
Are the cabinets/ refrigerators locked at home?	☐Yes☐No
Is the family current on PWS research?	☐Yes☐No
Does a family member belong to a PWS support group or network?	☐Yes☐No

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FOR AGENCY USE ONLY

_____ Screening Interview _____Assessment Visit
(date)

_____Accepted _____Rejected _____Withdrew_____Intake
(date)