



Passage
to a brighter
future

*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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	Place of Birth

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:

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

		If Yes, Specify
DDS/Current ISP	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Guardianship	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rogers Petition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DCF Involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CHINS	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arrests	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Probation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Trusts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DMH	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> 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)

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Current Diagnoses: Include all Medical and Psychiatric

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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 PHYSICIAN 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician (Psychiatric)	Last appt. date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dental	Last appointment date and results:
Dentist Name:	(Dental appointment must be within last 6 months)
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician (Eye)	Last appointment date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician (Other)	Last appointment date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physician (Other)	Last appointment date and results:
Name:	
Address:	
Tel. No.:	
May we Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No	

PAST MEDICAL HISTORY:

Communicable Diseases:

Has individual ever had	Yes	No	Date
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rubella	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Hospitalizations/Operations:

<u>Date</u>	<u>Reason</u>	<u>Hospital</u>	<u>Doctor</u>

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suicidal Thoughts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Phobias	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mood Swings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Feeling of Worthlessness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rapid Cycling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of Control	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nightmares	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Terrors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hoarding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Self-Injurious Behavior	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Elopement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fire Setting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rumination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	PICA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Makes False Accusations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Peers <input type="checkbox"/> Staff <input type="checkbox"/> Family <input type="checkbox"/>		
Picking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin <input type="checkbox"/>	Rectal <input type="checkbox"/>	
Aggression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Verbal <input type="checkbox"/>	Physical <input type="checkbox"/>	

Growth and Development:

Child			
Describe strengths:			
Describe weaknesses:			
Describe how individual interacts with others in the family. With peers.			
Does the Individual exercise daily?		<input type="checkbox"/> Yes <input type="checkbox"/> No	For how Long:
Does the individual Steal?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a Behavior Plan in use?		<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>	School <input type="checkbox"/>	Bus <input type="checkbox"/>	In Public Place <input type="checkbox"/>
What coping mechanisms work for the individual?			
Is any Counseling received?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes what type	Family <input type="checkbox"/>	Individual <input type="checkbox"/>	Group <input type="checkbox"/>
Are sensor alarms used in the house?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there alarms installed on windows and doors			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, For how long?			
Reason installed			

Is a special seat belt used for transportation on a school bus or van?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type	

What level of supervision is needed in the community?			
Full Supervision <input type="checkbox"/>	Some Supervision <input type="checkbox"/>	Some Independence <input type="checkbox"/>	Full Independence <input type="checkbox"/>

Can individual carry money?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can individual use public transportation independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can individual spend time alone at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, How long?	
Does individual use telephone appropriately?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, How Long?	
Orders take-out food to be delivered when unsupervised?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does individual have any vocational or work experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:	
Does individual use a computer?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/>	Calories counted <input type="checkbox"/>	Eats what family eats <input type="checkbox"/>
Describe how individual acts in public where food is available.			
Does the individual food seek?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes:	in the neighborhood <input type="checkbox"/>	Garbage <input type="checkbox"/>	School <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/>

