TANAGER PLACE
YOUR CHILD : OUR FOCUS

The documents that follow are the application for Tanager Place Inpatient Programs. You will find an application, social history, and medical history form.

You will also find Consent To Release And Exchange Information forms allowing current or recent providers to share information about the child. Complete the child's name and date of birth. Complete the name of person/organization section for agencies the child has received mental health services from. Examples are: psychiatrist/physician, hospital, prior out of home placements, therapist/counselor, in-home workers, DHS, and school. We will use these consent forms to request treatment records. These records will help us determine if our program is appropriate for the child. We are unable to accept an application without completed consent forms.

An admission staff will contact you after records have been received and reviewed by our clinical team. We will let you know if the child has been accepted for our program, or will make recommendations for alternative services.

Additional information can be found on our website at www.tanagerplace.org

Please contact me with any questions.

Sincerely,

Nicole Kilburg, MPA, LBSW
Admissions Coordinator
Ph: 319-365-9165 x330
nkilburg@tanagerplace.org

Tanager Place
2309 C Street SW
Cedar Rapids, IA 52404
Fax: 319.365.6411

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Application for Inpatient Services

Child's Name**:** _____ DOB:_____
Gender: ☐Female ☐Male SS#: _____

Child's Primary Household:
Caregiver 1:_____ **Caregiver 2:** _____

Relationship: _____ Relationship: _____
☐ Biological ☐Adopted ☐Step ☐Legal Guardian ☐ Biological ☐Adopted ☐Step ☐Legal Guardian
☐ Other_____ ☐ Other_____

Occupation: _____ Occupation: _____

Address/City/State/Zip:_____

Home Phone: _____ Cell 1: _____ Cell 2: _____

Email 1: _____ Email 2:_____

Child's Secondary Household:

Caregiver 1:_____ **Caregiver 2:** _____

Relationship: _____ Relationship: _____
☐ Biological ☐Adopted ☐Step ☐Legal Guardian ☐ Biological ☐Adopted ☐Step ☐Legal Guardian
☐Other _____ ☐ Other _____

Occupation: _____ Occupation: _____

Military status: _____ Military status: _____

Address/City/State/Zip:_____

Home Phone: _____ Cell 1: _____ Cell 2: _____

Email 1: _____ Email 2:_____

Does the child have any of the following resources?

Medicaid	☐Yes	☐No	If yes, ID number:
Private Insurance	☐Yes	☐No	If yes, company:
Social Security Benefits	☐Yes	☐No	If yes, amount:
Child Support	☐Yes	☐No	If yes, amount:
Adoption Subsidy	☐Yes	☐No	If yes, amount:

If your child receives any of the above sources of income, you will be required to these amounts toward the cost of the child's care.

Child's Name: _____

Is your child utilizing any of the following? If yes, please provide clinician and office name

Psychiatrist (or other medication manager) Yes ☐ No ☐

_____

Provider name Office/agency name

Psychologist Yes ☐ No ☐

_____

Provider name Office/agency name

Therapist/Counselor Yes ☐ No ☐

_____

Provider name Office/agency name

In home services Yes ☐ No ☐

_____

Provider name Office/agency name

Integrated Health or Child Mental Health Waiver Yes ☐ No ☐

_____

Provider name Office/agency name

Department of Human Services or Juvenile Court Services Yes ☐ No ☐

_____

Provider name Office/agency name

Other Current Service Providers: (Please list provider name and service provided)

_____

_____

_____

_____

Previous services: (Please include things such as psychiatric hospitalizations, shelter stays, residential treatment programs, day treatment programs, etc. as well as approximate dates.) Dates:

Description: From: To:

_____

_____

_____

_____

Individual completing application: _____

Best way to contact you? ☐ Phone: _____ ☐ Email: _____

How did you find out about our services? _____

_____ _____

Signature of parent/guardian Date

TANAGER PLACE
YOUR CHILD : OUR FOCUS

ADMIT MEDICAL HISTORY-***Form must be completed in full helping us to provide the best health care for your child.***

Child's Name: _____Date of Birth: _____Medicaid #:_____

Allergies: (drugs, food, latex, other) and reaction:_____

Immunizations up to date: yes□ no□ If no, explain_____

Has your child had a history of or any problems with the following?

Seizures/Epilepsy	yes□	no□	Muscle/Bone/Joint Issues	yes□	no□
Tremors	yes□	no□	Nosebleeds	yes□	no□
Asthma	yes□	no□	Ear Tubes	yes□	no□
-Use Inhaler?	yes□	no□	Hearing Impaired	yes□	no□
Tuberculosis	yes□	no□	-Use Hearing Aids?	yes□	no□
Heart Murmur	yes□	no□	Menstruation Issues	yes□	no□
Congenital Heart Problems	yes□	no□	Current Pregnancy?	yes□	no□
Artificial Heart Valves	yes□	no□	Sexually Transmitted Diseases	yes□	no□
High Blood Pressure	yes□	no□	HIV/AIDs	yes□	no□
Stroke	yes□	no□	Cancer or Radiation Treatment	yes□	no□
Constipation/Diarrhea	yes□	no□	MRSA	yes□	no□
GERD/Acid Reflux	yes□	no□	Chicken Pox	yes□	no□
Eating Disorders	yes□	no□	Meningitis	yes□	no□
Urinary Tract Infections	yes□	no□	History of Substance Abuse	yes□	no□
Kidney Problems	yes□	no□	Tobacco use	yes□	no□
Diabetes	yes□	no□	Psychiatric Care?	yes□	no□
Hepatitis or Liver Disease	yes□	no□	Autism	yes□	no□
Anemia	yes□	no□	ADHD or ADD	yes□	no□
Bleeding problems	yes□	no□	Developmental Disability?	yes□	no□
Skin Issues (Eczema, Psoriasis, etc.)	yes□	no□	Antibiotics needed before dental treatment?	yes□	no□
			Dental Issues?(toothache, soreness, swelling)	yes□	no□

If yes to any above explain:_____
_____
_____
_____
_____

yes□ no□ Speech Therapy, Occupational Therapy, Physical Therapy?_____

yes□ no□ No Does the child have physical limitations that impact their ability to bathe or toilet independently?

If yes, explain: _____
_____

Hygiene: □Poor □Fair □Good

yes□ no□ Special Dietary Accommodations? _____

Please list any other medical history not listed above: _____
_____
_____

Any recent diagnostic testing (EKG, Ultrasounds, Labs, X-rays, etc.)? YES□ NO□

*If yes, explain*_____

Surgical History/Hospitalizations:

Date	Reason/Type	Comment

Nursing comments regarding above info:

Child's Name: _____

Current Medications

Date of initial prescription or refill:	List current prescriptions and over-the-counter medications:	Dosage:	Prescribed by:	(For Nursing Use) Date/Time last dosage taken:

(Use a separate page if more room is needed to list all medications)

MEDICAL PROVIDERS

Primary Care

Physician _____

Address/City/State/Zip _____

Phone _____ Date of Last Physical Exam _____

Height _____ Weight_____

Dental

Dentist / Clinic_____

City/State _____ Phone _____

Date of Last Visit _____ Follow-up / Next Visit _____

Has antibiotic medicine been required before dental treatment? Yes No

Current toothache, sores or swelling in the mouth? Yes No

Other dental problems? Yes No

Requires help with tooth brushing? Yes No

Thumb, finger or pacifier sucking? Yes No

If yes, please explain:_____

Orthodontist / Clinic _____

City/State _____ Phone _____

Date of Last Visit _____ Follow-up / Next Visit _____

Please explain condition and treatment provided _____

_____

Vision

Optometrist / Clinic_____

City/State _____ Phone _____

Date of Last Visit _____ Follow-up / Next Visit _____

Does the child have glasses or contacts? Yes No If yes, how often are glasses or contacts to be worn?

_____

Are glasses/contacts with the child? Yes No

Child's Name: _____

Additional information you wish to share about your child's health: _____
_____
_____
_____

FAMILY MEDICAL HISTORY

___ Heart Problems
___ Hepatitis
___ Epilepsy / Seizures
___ Cancer
___ Diabetes
___ Genetic / Inheritable Conditions
___ Chronic Illness
___ Other _____

___ Mental Illness
___ Intellectual Disability
___ Alcoholism
___ Substance Use

M=Mother A=Aunt GM=Grandmother S=Sibling
F=Father U=Uncle GF=Grandfather

I agree this information is accurate to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE:_____DATE: _____

TANAGER PLACE NURSE SIGNATURE: _____ DATE: _____

For Tanager Place Nurses Use Only:

Count of Controlled Substance: #_____ _____/_____

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Inpatient Social History

The following information is important in planning for your child's treatment. Please complete to the best of your ability. Feel free to add additional comments.

Child's Name: _____ DOB: _____

Referring Issues

The main behaviors that have led to seeking placement are (give specific examples):

_____
_____
_____

When did these behaviors begin? (age of the child, significant events occurring at the time, family changes)

_____
_____

Birth

Pregnancy and Delivery

☐ Yes ☐ No Use of substances during pregnancy_____
☐ Yes ☐ No Were there complications during pregnancy or with child's birth?_____
_____
☐ Yes ☐ No Did client require special attention in the first few weeks/months of life? _____
_____
☐ Yes ☐ No Were developmental milestones met within normal limits? _____
_____

Delivery: Full term ☐ Premature ☐ Normal Delivery ☐ C-Section Delivery ☐

Are there concerns about the following:

☐ Yes ☐ No Speech and/or language _____
☐ Yes ☐ No Learning _____
☐ Yes ☐ No Autism Spectrum _____
☐ Yes ☐ No Nightmares _____

Social Development

☐ Yes ☐ No Has problem getting along with peers
☐ Yes ☐ No Gets into fights
☐ Yes ☐ No Is withdrawn/prefers being alone
☐ Yes ☐ No Is bossy
☐ Yes ☐ No Is a bully
☐ Yes ☐ No Can make friends
☐ Yes ☐ No Can keep friends
☐ Yes ☐ No Demonstrates age-appropriate skills
☐ Yes ☐ No Is able to share
☐ Yes ☐ No Initiates positive interactions
☐ Yes ☐ No Is a group leader
☐ Yes ☐ No Is a group follower

Name: _____

Cognitive/Emotional Development

Check yes or no for each statement and explain:

☐ Yes ☐ No Seems to be disoriented _____

☐ Yes ☐ No Confused or odd thinking _____

☐ Yes ☐ No Unusual thinking/Odd ideas _____

☐ Yes ☐ No Confusion of fantasy and reality _____

☐ Yes ☐ No Confusion of dreams and reality _____

☐ Yes ☐ No Hears voices/Sees visions _____

☐ Yes ☐ No Unusual/Irrational fears _____

☐ Yes ☐ No Paranoid/Afraid of others _____

☐ Yes ☐ No Off-task/Unfocused/ Disorganized _____

☐ Yes ☐ No Irritability/Temper outbursts _____

☐ Yes ☐ No Severe anxiety/Panic attacks _____

☐ Yes ☐ No Threats to kill self _____

☐ Yes ☐ No Threats to kill others _____

☐ Yes ☐ No Impulsive _____

☐ Yes ☐ No Refuses to do what s/he is asked _____

☐ Yes ☐ No Aggression (to who, how often) _____

☐ Yes ☐ No Hurts animals _____

☐ Yes ☐ No Destroys property _____

☐ Yes ☐ No Runs away (how often, how long) _____

☐ Yes ☐ No Starts fires _____

☐ Yes ☐ No Steals _____

☐ Yes ☐ No Repetitive behaviors (banging head, flapping, twirling, rocking) _____

☐ Yes ☐ No Injures self (cuts, hits, bites, etc.) _____

☐ Yes ☐ No Pulls out hair or eyelashes _____

Name: _____

Activities of Daily Living

Does the child have problems:

☐ Yes ☐ No Falling Asleep _____
☐ Yes ☐ No Staying asleep _____
☐ Yes ☐ No Waking early _____
☐ Yes ☐ No Problems waking _____
☐ Yes ☐ No Nightmares _____
☐ Yes ☐ No Bedwetting _____
☐ Yes ☐ No Daytime wetting pants _____
☐ Yes ☐ No Soiling pants _____

Vocational History

Current employment: _____

Employment history: _____

Education

Current School: _____ Current Grade: _____

☐ Yes ☐ No Does your child have a 504 plan?
☐ Yes ☐ No Does your child have an IEP?
If yes, are the goals: ☐ Yes ☐ No Learning ☐ Yes ☐ No Behavioral

☐ Yes ☐ No Does your child attend an alternative school/setting?
☐ Yes ☐ No Does your child have a shortened school day?
☐ Yes ☐ No Does your child have a 1 on 1 staff?
☐ Yes ☐ No Does your child have accommodations for transportation to and from school?

☐ Yes ☐ No Behavior problems in school _____
☐ Yes ☐ No Learning disabilities _____
☐ Yes ☐ No Attendance problems _____
☐ Yes ☐ No Suspensions or expulsion Frequency: _____

Extracurricular activities/hobbies: _____
_____

Addictive Substances

Caffeine ☐ Yes ☐ No ☐Past ☐Current Frequency _____
Nicotine ☐ Yes ☐ No ☐Past ☐Current Frequency _____
Alcohol ☐ Yes ☐ No ☐Past ☐Current Frequency _____
Illegal Drugs ☐ Yes ☐ No ☐Past ☐Current Frequency _____

Over the Counter Medication for recreational use ☐ Yes ☐ No ☐Past ☐Current Frequency_____

Prescription Medication for recreational use ☐ Yes ☐ No ☐Past ☐Current Frequency_____

Other: _____ ☐ Yes ☐ No ☐Past ☐Current Frequency_____

Name: ______________________________

Sexual Development

☐ Yes ☐ No Do you have concerns about your child's sexual behavior and/or development? (early/late development, sexual identity, sexual activity). Please explain: ______________________________________

____

____

____

History of Trauma

☐ Yes ☐ No Physical abuse. If yes, by whom? ____

☐ Yes ☐ No Emotional abuse. If yes, by whom? ____

☐ Yes ☐ No Neglect/Denial of critical care. If yes, by whom? ______________________________________

☐ Yes ☐ No Sexual abuse. If yes, by whom? ____

☐ Yes ☐ No Witnessed abuse. If yes, what age? ____

☐ Yes ☐ No Inappropriate sexual behavior. If yes, with who? _____________________________________

☐ Yes ☐ No Natural disasters ____

☐ Yes ☐ No Significant accidents/injuries ____

☐ Yes ☐ No Had someone close to them pass away ____

☐ Yes ☐ No Separated from primary caregiver ____

☐ Yes ☐ No Placed in foster care ____

If Yes:

How old was the child at the time? ____

How many families did the child live with? ____

How long was the child in foster care? ____

☐ Yes ☐ No Other Trauma ____

Cultural

Cultural Considerations for the child or family: ____

____

Language Considerations for the child or family: ____

____

Religious/Spiritual Beliefs: ____

____

Family/Household Members

Name:	Age	Do they live in the home?	If not, is there contact?
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA
______________________________		☐Yes ☐No	☐Yes ☐No ☐NA

Name: _____

Family History

Depression	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Anxiety	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Suicide (including attempts)	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Bipolar Disorder	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Schizophrenia	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
ADHD	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Alcoholism	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Drug Abuse	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Parent in Prison	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Domestic violence	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____
Physical Illness	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Other _____

Who is the child closest to in the immediate and extended family?

What does your family do together for fun? What are your interests and hobbies?

What are the rules of the house?

What happens when rules are broken? Who enforces the rules?

Name: _____

What are your family's strengths? Please list at least 5 things.

What does the family need to work on while the child is in treatment? What changes will need to be made in your home for the child to be successful at discharge?

What are your child's strengths? Please list at least 5 things.

What does the child need to work on in treatment?

What are your expectations of Tanager Place while your child is in treatment?

_____ _____

Signature of Parent/Guardian Date