

Statement of Need for Hawthorn/Cottonwood Residential Care Services

- A Licensed Qualified Mental Health Professional completes this form.
 - Attach a copy of the most recent psychiatric evaluation
 - Attach the last three psychiatric progress notes/med notes
 - Submit this form and all attachments with referral packet for residential care services

Date: _____

Child/Youth: _____ DOB: _____

Parent/Legal Guardian: _____ Contact Information: _____

1) What is the presenting problem?

2) Has the child/youth experienced a history of trauma? (Include abuse, neglect, and loss by divorce or death):

Yes No

If yes, describe and include child's age at the time of traumatic event and dates.

3) What is the current diagnosis of the child/youth?

4) What information is pertinent in regards to the child/youth's physical health?

5) What information, if any, is pertinent in regards to the child/youth's co-occurring medical, developmental disability, and/or substance use history?

6) **Child/youth usually:**

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| Dresses appropriate to the occasion/weather | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Shows signs of self-care, hair combed, etc. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Is straightforward and easy to observe | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Speaks and is easily understood | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Deals well with visitors to his/her home | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Relates well with family members | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Is able to maintain friendships/supportive relationships | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Can compare and evaluate facts, ideas and choices | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Appears to be stable and not volatile | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If “Yes” to any of the following, please describe below:

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| Shows signs of bizarre mannerisms or facial features | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Demonstrates twitching, stiffness, shakes | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Is concerned about plotting or seeking revenge | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Is repeatedly talking about one subject | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Is performing repeated actions | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Appears depressed, sad, or helpless | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Is unresponsive to questions/limits self in conversation | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

7) Is it your opinion that all available community-based resources have been accessed but have been unable to stabilize this child/youth’s clinical needs effectively?

Yes No

If no, please describe the **special circumstance** providing the reason these community services have not been provided and/or reasons community based resources could more effectively stabilize this child/youth but have not.

8) Do you recommend residential placement as a clinically necessary service for this child/youth at this time?

Yes No

If yes, describe why you are recommending residential placement at this time, include discharge criteria and preliminary plans at discharge. (Use additional space as needed on the back of this form.)

Name of Licensed QMHP (Print)

Signature

Additional comments: