

OLD VINEYARD BEHAVIORAL HEALTH SERVICES



Dear Professional,

Thank you for your interest in Old Vineyard Behavioral Health Services’ Psychiatric Residential Treatment Facility (PRTF) Programs. We are sending you this information because you have indicated you have a potential referral. You can also access this information at our website www.oldvineyard.net via the Admissions link. All referrals will need to have a case manager involved in the patient’s care.

In order to consider a person for potential residency in one of our PRTF Programs, we must obtain the following information:

COMPLETED Application	All Referrals - We will not review applications that are not completed in full. Please review the application prior to submission to ensure there are no “blanks” prior to submission.
Person Centered Plan (PCP)	All Referrals
Psychological Evaluation w/ Full Scale IQ	All Referrals
School Records / IEP	All Referrals
Copy of Medicaid / Insurance Cards	All Referrals
Any Discharge Summary, Psychiatric Evaluation, or Other Diagnostic Assessment if Completed	All Referrals
Court / DJJ Records	All Referrals
Sex Offender Specific Evaluations	All Referrals to our Sexually Reactive / Sexual Offender Programs
ITR	All Medicaid Referrals Authorized by Value Options
TAR	All Medicaid Referrals Authorized through Piedmont Behavioral Health (PBH)

Information can be faxed to 336-794-4286 or mailed to Old Vineyard Behavioral Health Services, 3637 Old Vineyard Road, Winston-Salem, NC 27104 to the attention of the PRTF Admissions Coordinator.

Once we have received the application in full, we will route it to the Clinical Director of PRTF Services for review. You will be verbally notified as to whether the client has been accepted, denied or pending any additional information within 72 hours of our receipt of the COMPLETED application packet. If the patient has been approved, we will notify you of anticipated admission date as well as instruct you on next steps in the application and authorization process.

Please find attached a brief summary of our programs in addition to a list of exclusionary criteria. If you have any additional questions regarding our programs or the application process, please contact Lisette Timberlake at 336-794-3585 or via email at lisette.timberlake@uhsinc.com. Again, we thank you for considering our facility to meet your client’s needs.

Regards,

Lisette Timberlake
 PRTF Admissions Coordinator
 Old Vineyard Behavioral Health Services
 336-794-3585

OLD VINEYARD BEHAVIORAL HEALTH SERVICES
PRTF UNIT DESCRIPTIONS

Perseverance Unit

The Perseverance Unit for males ages 15-17 with an IQ of 80 or higher is a specialized treatment program for adolescent males who engage in sexually reactive, abusive and/or sexually aggressive behaviors towards others, in addition to general behavioral/ psychiatric problems that require the youth to be placed in a secure and safe environment because the youth cannot be maintained safely in the community.

The program is designed to treat residents using a combination of cognitive-behavioral treatment (CBT), trauma focused cognitive behavioral treatment (TF-CBT), and sex-offense specific treatment programming.

This program admits youth based upon three principles:

- risk for sexual dangerousness
- the special psychiatric and treatment needs of the youth
- the responsivity principle ~ that the treatment and interventions match the needs and characteristics of the youth.

Phoenix Unit

The Phoenix Unit for males ages 11-15 with an IQ of 80 or higher is a specialized treatment program for adolescent males who engage in sexually abusive and sexually aggressive behaviors towards others, in addition to general behavioral/ psychiatric problems that require the youth to be placed in a secure and safe environment because the youth cannot be maintained safely in the community.

The program is designed to treat residents using a combination of cognitive-behavioral treatment (CBT), trauma focused cognitive behavioral treatment (TF-CBT), and sex-offense specific treatment programming.

This program admits youth based upon three principles:

- risk for sexual dangerousness
- the special psychiatric and treatment needs of the youth
- the responsivity principle ~ that the treatment and interventions match the needs and characteristics of the youth.

Pride Unit

The Pride Unit for males ages 12-17 with a full IQ of 80 or higher is a specialized treatment program for adolescent males who have a history of sexual issues, substance/alcohol abuse, high-risk behavior, self-injury and/or violent behavior, in addition to general behavioral/ psychiatric problems that require the youth to be placed in a secure and safe environment because she cannot be maintained safely in the community.

A combination of cognitive-behavioral treatment (CBT), trauma focused cognitive behavioral treatment (TF-CBT), and person centered care is utilized to treat their psychiatric needs. This program admits youth based on three principles: 1) risk of harm to self or others, 2) need for the special psychiatric and treatment needs of the youth, and 3) the responsivity principle that the treatment and interventions match the needs and characteristics of the youth.

Perfection Unit

The Perfection Residential Treatment Unit for females ages 13-17 is a specialized treatment program for adolescent females who have a history of sexual issues, substance/alcohol abuse, high-risk behavior, self-injury and/or violent behavior, in addition to general behavioral/ psychiatric problems that require the youth to be placed in a secure and safe environment because she cannot be maintained safely in the community.

A combination of cognitive-behavioral treatment (CBT), trauma focused cognitive behavioral treatment (TF-CBT), and person centered care is utilized to treat their psychiatric needs. This program admits youth based on three principles: 1) risk of harm to self or others, 2) need for the special psychiatric and treatment needs of the youth, and 3) the responsivity principle that the treatment and interventions match the needs and characteristics of the youth.

OLD VINEYARD BEHAVIORAL HEALTH SERVICES
RESIDENTIAL SERVICES APPLICATION

Date of Application _____ Date Service Needed: _____

Type of Referral: Sexually Reactive/Offender Unit _____ General Psychiatric _____

CONSUMER INFORMATION

Consumer's Name: _____ Nickname: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: _____ Race _____

Medicaid Number: _____ County: _____ Weight: _____ Height: _____

Consumer's Current Address: _____

Consumer's Phone Number: _____ Current Living Arrangement _____

Place of Birth: _____ Primary Language _____

Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.): _____

GUARDIAN INFORMATION

Legal Guardian _____

Relationship: _____ County of Legal Custody: _____

Guardian's Address: _____

Guardian's Phone Number: H _____ W _____ O _____

If a Guardian ad Litem has been appointed please list name and contact information: _____

CONSUMER'S PRIMARY REFERRAL SOURCE INFORMATION

Referring Agency: Community Support DJJ DSS County: _____

Other: _____

Provider Agency: _____ Phone #: _____ Fax #: _____

Agency Contact Person: _____ Phone #: _____ Fax #: _____

Address: _____

Emergency Contact Person: _____ Relationship to Client _____
 Telephone: _____ Pager/Cell: _____ Fax: _____
 Address: _____

CLINICAL/DIAGNOSTIC INFORMATION

DSM IV-TR Multi-Axial Diagnosis

Diagnoses :	Date :	Source:
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		

Calocus Score:

IQ: _____ Verbal _____ Performance _____ Full Scale _____

Examiner: _____ **Date:** _____

- History of Abuse:** Victim of Neglect Victim of Physical Abuse
 Victim of Sexual Abuse Victim of Emotional Abuse
 None

If checked please provide a written description. If DSS involvement please attach documentation. _____

Medications	Prescribing Physician	Dosage/Frequency	Date Started / Compliant?

Medical Conditions (past and present) Please note most recent occurrence

- | | | |
|---|---|---|
| <input type="checkbox"/> Lice | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Measles | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mumps | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Ringworm | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Chronic Urinary / Bowel Problems | <input type="checkbox"/> Rubella | <input type="checkbox"/> Traumatic Brain Injury |
| Other: _____ | Other: _____ | Other: _____ |

MEDICAL INFORMATION

Allergies: _____

Special Dietary Needs: _____

Name and Address of Pediatrician: _____

Name and Address of Dentist: _____

Date of Last Phys. Exam: _____ Last Dental Exam: _____ Last Eye Exam: _____

Dental Appliances: Yes No Contacts/Glasses: Yes No

Medical Insurance Company: Medicaid _____ NC Healthchoice _____

Private Ins.(Agency) _____

Insurance Policy Number: _____

Insurance is in whose name? _____

Any other third party insurance? _____

PRESENTING PROBLEMS / REASON FOR REFERRAL

PREVIOUS TREATMENT INITIATIVES

Outpatient Intervention	Date	Effectiveness

OLD VINEYARD BEHAVIORAL HEALTH SERVICES

PLACEMENT HISTORY		
Placement (Begin w/Current Placement)	Dates (From – To)	Reason for Discharge

CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS		
Please describe behavior and include the date of last incident.		
<input type="checkbox"/> Abandonment Issues	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arson
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Antisocial Behavior	<input type="checkbox"/> Difficulty With
<input type="checkbox"/> Assaultive (Physical)	<input type="checkbox"/> Assaultive (Sexual)	<input type="checkbox"/> Assaultive (Verbal)
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Destroying Property	<input type="checkbox"/> Fire Setter	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Homeless	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Impulsive
<input type="checkbox"/> Lying	<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Loss/Grief Difficulties
<input type="checkbox"/> Physical Impairment	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Parent Neglect Issues
<input type="checkbox"/> Perception of Reality	<input type="checkbox"/> Phobic Behavior	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Self Destructive Behavior	<input type="checkbox"/> Sibling Related Difficulty	<input type="checkbox"/> Oppositional
<input type="checkbox"/> Social Immaturity	<input type="checkbox"/> Sexually Inappropriate Behavior	<input type="checkbox"/> Stealing
<input type="checkbox"/> Suicidal	<input type="checkbox"/> Running Away	<input type="checkbox"/> Truancy
<input type="checkbox"/> Unruly/Ungovernable	<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Hygiene/Cleanliness Issues
<input type="checkbox"/> Problems with Sleep	<input type="checkbox"/> Gang Related Activity	<input type="checkbox"/> History w/ Weapons
<input type="checkbox"/> Property Destruction	<input type="checkbox"/> Stool/Feces smearing	
Other: _____		

FAMILY INFORMATION	
Biological Mother's Name: _____	
Address: _____	
Telephone Number: Home: _____ Work: _____ Cell: _____	
Ethnicity _____ Educ. Level: ____ Unknown ____ Criminal Record: _____ (Yes/No) Unknown _____	
Biological Father's Name: _____	

OLD VINEYARD BEHAVIORAL HEALTH SERVICES

Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Ethnicity _____ Educ. Level: ___ Unknown ___ Criminal Record: _____ (Yes/No) Unknown

Are Parents: Married Separated Divorced Never Married Deceased Mother Deceased Father

Have parental rights been terminated: _____ If so, who and when? _____

How many siblings does Consumer have: _____

Age	Gender	Name	Age	Gender	Name

Are siblings in out-of-home placements? _____

If yes, please specify: DSS Foster Care Relatives
 Incarcerated Group Home
 Other: _____

FAMILY DYNAMICS / FAMILY SOCIAL HISTORY

Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked please explain.

<input type="checkbox"/> Criminal Activity	<input type="checkbox"/> Child Abuse
<input type="checkbox"/> Inappropriate Sexual Behavior	<input type="checkbox"/> Treatment Disruption
<input type="checkbox"/> Psychiatric Illness	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Suicide	Other: _____

If other pertinent family history please document separately and attach.

AUTHORIZED CONTACTS

Name	Relationship	Address	Telephone Number	Types of Contact With Client (supervised, letter, etc.)	Date of Release of Information

Are there any special conditions/restrictions for visits home?

Any "no contact" orders?

SCHOOL INFORMATION

Last School Enrolled: _____

District: _____ Grade: _____

Special Classes: EH LD Resource BEH _____
Homebound Other: _____

Any history of truancy? _____ Grades Repeated: _____

Current IEP? Yes No Date: _____

Suspensions/Expulsions: _____

AGENCY INVOLVEMENT

Indicate all agencies currently involved:

DSS Mental Health Provider _____
DJJ Voc Rehab Other: _____

COURT HISTORY

Does Consumer have a criminal record? Yes No Has consumer been convicted of any sex offence? Yes No

Is the consumer on the North Carolina sex offender registry? Yes No

Offenses	Conviction Dates	Tried as Juvenile Or Adult
_____	_____	_____
_____	_____	_____

Pending Charges: _____

Is Consumer on Probation? _____ Name and Contact #of Court Official _____

Is placement court ordered? Yes No (If "Yes, attach court order)

TREATMENT GOALS

Please attach copy of Person Centered Plan/ Individual Support Plan (if applicable) that includes service being requested.

History of Self Injury and Risk Behaviors

Self Injury	<input type="checkbox"/> cuts on body <input type="checkbox"/> conceals cutting- indicate area <input type="checkbox"/> other forms of self injury (please describe) Has self-injury ever required medical attention? Please explain:
Suicidal Characteristics	Check all that apply <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Past Suicide Attempts <input type="checkbox"/> Suicidal Plans Describe: Methods used in previous attempts- please describe: Were attempts planned: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> sometimes <input type="checkbox"/> don't know
Homicidal Characteristics	Check all that apply <input type="checkbox"/> homicidal thoughts <input type="checkbox"/> Past Attempts to harm others <input type="checkbox"/> Homicidal Plans Describe: Methods used in previous attempts- please describe: Were attempts planned: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> sometimes <input type="checkbox"/> don't know Does consumer have access to weapons? Please explain

History of AWOL	<input type="checkbox"/> Runs away from home <input type="checkbox"/> Has run from previous placements In the past year how many times has consumer run? ____ Where does he/she go? : How long is typically AWOL? :																														
Substance Abuse History	<table border="1"> <thead> <tr> <th>Type of Substance</th> <th>Frequency</th> <th>Last Use</th> <th>Type of Substance</th> <th>Frequency</th> <th>Last Use</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Marijuana</td> <td></td> <td></td> <td><input type="checkbox"/> Amphetamines</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cocaine</td> <td></td> <td></td> <td><input type="checkbox"/> Hallucinogens</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Heroin/Opiates</td> <td></td> <td></td> <td><input type="checkbox"/> Alcohol</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Inhalants</td> <td></td> <td></td> <td><input type="checkbox"/> Other:</td> <td></td> <td></td> </tr> </tbody> </table>	Type of Substance	Frequency	Last Use	Type of Substance	Frequency	Last Use	<input type="checkbox"/> Marijuana			<input type="checkbox"/> Amphetamines			<input type="checkbox"/> Cocaine			<input type="checkbox"/> Hallucinogens			<input type="checkbox"/> Heroin/Opiates			<input type="checkbox"/> Alcohol			<input type="checkbox"/> Inhalants			<input type="checkbox"/> Other:		
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Sexualized Behaviors	Please describe any sexualized behaviors exhibited by consumer (i.e. exposure, sexual acting out, predatory behaviors, prostitution)																														
Psychotic Behaviors	Please describe any past/present history of psychosis																														

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ADDITIONAL COMMENTS

Please use this space to include any additional comments that may support this application

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REFERRAL CHECKLIST

In 2nd column please indicate each item that is being attached to this packet. Please comment on reasons items are missing or items that will be sent at later time.

Universal Application	
Person Centered Plan / Sign Page	
Discharge Summaries from Hospitalizations/ Previous Treatment	
School Records/ IEP	
DSS records (if applicable)	
DJJ records (if applicable)	
Psychological Testing w/ Full Scale IQ	
Sexually Aggressive Youth Evaluation / Sex Offender Specific Evaluation	
Immunization Records	
Copy of Medicaid/ Insurance Cards	
Psychiatric evaluations	
ITR	
Court/Custody Orders	

