

West Central Regional Juvenile Center Secure Residential Program Referral Information

Phone: 218.299.5150 Email: wcrjc@co.clay.mn.us Fax: 218.299.7533



Client Personal Information					
Client's Full Name		Alias(es)		Date of Birth	
Gender Male Female		Social Security Number		Place of Birth	
Permanent Address		City		State	Zip Code
Race/Ethnicity		Language		Height	Weight
Tribal Affiliation if applicable:		Legal Custodian		Client Phone Number	
Billable County		Entity Responsible for Payment		Program Admission Date	
Placement Status Delinquency Extended Juvenile Jurisdiction		Court Date		Court File Number	
Program Length Desired 60 days 90 days 120 days 180+ days transitional program Other:					
Services Desired Substance Abuse Sex Offense Specific Trauma Therapy Other:					
Medical Insurance Provider: Policy #:			Secondary Insurance Provider: Policy #:		

Contact Information					
Legal Guardian/Parent					
Parent/Guardian Name		Does the child reside with this parent? Yes No		Allowed to have contact? Yes No	
Street Address		City		State	Zip Code
Cell Phone		Home Phone		Work Phone	
Parent/Guardian Name		Does the child reside with this parent? Yes No		Allowed to have contact? Yes No	
Street Address		City		State	Zip Code
Cell Phone		Home Phone		Work Phone	

Will both parents be involved with the child's stay? Yes No		Who has custody of the child?	
Any other important information about parents/guardians:			
Placing Agent			
Referring Agent		Agency	Email Address
Office Phone		Alternate Phone	Fax
City	State	Zip	Preferred method of contact Phone Email
Social Workers, Case Workers, and Other Professionals Involved with Client			
Worker's Name/Title		Agency	
Phone		Email Address	
Worker's Name/Title		Agency	
Phone		Email Address	
Worker's Name/Title		Agency	
Phone		Email Address	

Client Offense History			
Date of Offense	Nature of Offense	Offense Level	Disposition

Placement History		
Facility/Agency Name	Dates of Placement/Discharge	Result

Treatment History			
Agency	Nature of Treatment	Dates of Admission/Discharge	Result

School History		
Client's Home School	Current Grade Level	Does client have an IEP? Yes No
School contact	Phone number/email	GED Route? Yes No

Client Medications		
Medication	Dosage	Taking as prescribed?

Client History
Underlying factors that led to client's referral:
Is there history of abuse or neglect? If so, please explain:
Are there any issues with self-harm? If yes, please explain:
Is the client assaultive or have any history of physical aggression? If yes, please explain:
Any mental health concerns or history of substance abuse? If yes, please explain:
Please list client's strengths, weaknesses, and abilities:

Please identify any other concerns or pertinent information:

Program Expectations

What are your expectations of this program in relation to the client? What skills should they have learned/developed?

Are there any additional services that you are requesting? If so, please list them:

What transitional services will your client benefit from?

Please list any additional questions, comments, or information you may have:

Please include any pertinent documents such as diagnostic assessments, substance use evaluations, discharge summaries, etc.