Alexander Youth Network
HYPE (SAIOP) Program
309 Concord Street
Greensboro, NC 27406
Contact Info: smitchell02@aynkids.org
Phone: (336) 542-0868 or Fax: (800) 975-8101

HYPE (SAIOP) Program
CHECKLIST AND INTAKE

Referral Date: ____________________ Birth Date: _____________________

Sex: Male ______ Race:_________________ SSN#: _______________________________

Client Name: ____

Address: _______________________________City __________________ State ____Zip______

Age: _________ Height: ___________ Eyes: __________________ Hair: _______________

Citizenship:________ Residing County:_______________ MCO/LME:_________________

Name of School: ____________________________ Phone # of School: __________________

School Counselor: ___________________________ Retained in School: __________________

Grade in School: _______________ Number of times suspended from School: ______________

Last date attended School: ___________ Type of School Schedule: _____________________

<u>PARENT/GUARDIAN INFORMATION</u>:

Name: _______________________________________ Relationship: _______________________

Address: ____________________________________ City __________________ State _______

Phone (Day): ______________________________ Phone (Night) __________________________

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History of family substance use/abuse: Yes No
Please give details if possible

Additional client information: History of violence: Yes No
Please give brief explanation if answered yes:

History of gang involvement: Please be honest and thorough in explanation. We need full disclosure for the safety of all clients in our facility. Please include the information on a separate page if necessary.

Current Diagnosis: Axis I-V, in Axis I **substance abuse/dependence should be listed as primary diagnosis along with any other oppositional and/or defiant behavior.**

Current prescribed medications client is taking. Please list and make sure family understands it is imperative that enough medication refills are supplied for the duration of the anticipated time he will remain in ASAP, which is 3-6 months. We must have written dr. orders for each prescribed medication. These forms will be supplied by ASAP staff upon initial referral.

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SUBSTANCE ABUSE HISTORY:

Outpatient: Number of times: ___________
(Give dates, locations, diagnosis)

____
____

Inpatient: Number of times: ___________
(Give dates, locations, diagnosis)

____
____

Drugs of choice: (1) ______________________________(2)______________________________

(3)____

Number of days clean: ___________

Does client need detox? Yes ______ No ______

Explain: ____

DJJDP/DOC Court involvement and is client court ordered? Yes ______ No ______

Charges: ____

Court Counselor: ____________________________ Phone Number: ______________________

Referral Source: ____________________________ Phone Number: ______________________

E-Mail for referral contact**:**____

MEDICAL INSURANCE:

Insurance: Yes ______ No _______ Policy # __________________________________

Medicaid: Yes ______ No _______ Medicaid # ________________________________

Beginning and ending dates for Medicaid Card: ______________ to _____________

REFERRALS CAN BE MADE BY CALLING (336) 336-542-0868 OR BY FAXING to (800) 975-8101, OR MAILING TO YOUTH FOCUS, INC., 309 CONCORD ST. GREENSBORO, NC 27406