



**NOVA ICF Services
Admission Application Packet**

Thank you for your interest in our ICF Program! Our Admissions Specialist will work with you throughout the application and admissions process. We will work hard to keep you informed on the status of your application.

To complete an admission application for ICF services, please submit the following documents:

- NOVA Admission Application (see below)
- Most recent psychological evaluation
- Most recent Person-Centered Plan (PCP) or Behavior Support Plan
- Educational Records
- Legal Guardianship documents
- List of current medications
- Immunization records
- Discharge summaries from previous services

When this information has been gathered, please submit all documents to our Admissions Specialist. We prefer you to email all documents to the Admissions Specialist, but you may also mail or fax the admissions application packet.

Admissions Team
Email: icfreferrals@novanc.org
Phone: 919-734-8803 ext. 1114
Fax: (919) 735-8871

**2307 Norwood Ave, Ste G.
Goldsboro NC 27534**

Thanks again for your interest in the ICF Program. We will contact you about your application as soon as possible!



**NOVA ICF Services
Admission Application**

<p>Patient Info:</p> <p>Name: _____</p> <p>DOB: _____</p> <p>Sex: _____</p> <p>Managed Care Organization: _____</p> <p>Current Placement: _____</p> <p>Duration at Current Placement: _____</p>	<p>Guardian Info:</p> <p>Guardian Name: _____</p> <p>Relation to patient: _____</p> <p>Guardian Address: _____</p> <p>Guardian Email: _____</p> <p>Guardian Phone: _____</p>
<p>Reason For Referral / Presenting Problem:</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>Diagnoses</p>	
<p>Intellectual Disability Diagnosis: _____</p> <p>Psychiatric Diagnoses: _____</p> <p>Physical Health Diagnoses: _____</p>	
<p>Medical History</p>	
<p>Please indicate all past and present medical conditions</p>	
<p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Migraine/Headaches</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Urinary/Bowel issues</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Other: _____</p>
<p><input type="checkbox"/> Measles/Mumps</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Traumatic Brain Injury</p> <p><input type="checkbox"/> Other: _____</p>	
<p>Date of Last Physical Exam: _____</p> <p>Date of Last Dental Exam: _____</p> <p>Date of Last Eye Exam: _____</p> <p>Allergy List: _____</p> <p>Special Dietary Needs: _____</p>	
<p>Primary Concerns / Target Behaviors:</p>	



- | | |
|--|--|
| <input type="checkbox"/> Elopement | <input type="checkbox"/> Inappropriate Sexualized Behavior |
| <input type="checkbox"/> Suicidality | <input type="checkbox"/> Property Destruction |
| <input type="checkbox"/> Non-suicidal self-harm | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Psychotic Behaviors |
| <input type="checkbox"/> Juvenile Justice / Criminal Charges | <input type="checkbox"/> Intellectual Disability |

Please provide additional information about each primary concern, noting the frequency and severity of each concern.

Please describe the individual's abilities in the following domains. Please indicate the degree to which the individual can perform each skill independently.

Speech/Communication:

Bathing/Personal Hygiene:

Dressing:

Toileting:

Dining:

Household chores:



Strengths and Preferences

What does he/she do for fun?

How does he/she spend their free time?

What antecedents/triggers lead the individual into outbursts or problematic behavior?

What comforts the individual when they are upset?

What else should we know in order to provide the individual with the best care possible?
