

## REFERRAL FORM

Name of person completing form: \_\_\_\_\_

Agency: \_\_\_\_\_

Contact Information: (Phone/Email): \_\_\_\_\_

Date: \_\_\_\_\_

Select requested service(s) from options below.

- Therapeutic Foster Care  
 Outpatient Therapy  
 Comprehensive Clinical Assessment

Date of most recent assessment (CCA), if applicable: \_\_\_\_\_

### I. Family Information

**Child:**

1. Child's Name: \_\_\_\_\_ 2. Nickname: \_\_\_\_\_  
Last First Middle

3. Address: \_\_\_\_\_  
Number Street/Unit City, State Zip Code

4. Date of Birth: \_\_\_\_\_ Verified? Yes \_\_\_ No \_\_\_ 5. Gender: Female: \_\_\_ Male: \_\_\_  
Month Day Year

6. Race: \_\_\_\_\_ 7. Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

8. Place of Birth: \_\_\_\_\_  
City State Country

9. Currently Living With: Biological Parents: \_\_\_ Relative: \_\_\_ Foster Family: \_\_\_ Other: \_\_\_\_\_  
(Specify)

10. Have proceedings been initiated to terminate parental rights for this Child's: Mother \_\_\_\_\_ Father: \_\_\_\_\_  
 If yes, give the date of the final order terminating parental rights of the Mother: \_\_\_\_\_ Father: \_\_\_\_\_

11. Has child been placed in foster care prior to referral: \_\_\_\_\_

## II. Custody

### Legal Guardian:

12. Name: \_\_\_\_\_ 13. Phone Number: \_\_\_\_\_  
Last First Middle

14. Address: \_\_\_\_\_ 15. Email: \_\_\_\_\_  
Number Street/Unit City, State Zip Code

### Contact Person:

16. Name: \_\_\_\_\_ 17. Email: \_\_\_\_\_  
Last First Middle

18. Phone Number: \_\_\_\_\_ 19. Alternate Number: \_\_\_\_\_

20. Is a "Voluntary Placement Agreement" in effect: (Circle one) Yes No If yes, expiration date: \_\_\_\_\_

### If child's current family has DSS involvement, please indicate reason for involvement and/or removal:

Goal for Foster Care: Choose One

\_\_\_\_ Return to Biological Family \_\_\_\_ Long Term Foster Care

\_\_\_\_ Independent Living \_\_\_\_ Placement with Relative

\_\_\_\_ Adoption \_\_\_\_ Other, Specify: \_\_\_\_\_

## III. Presenting Problem

Please provide details of what is currently going on in the family at this time. Describe the significant events which affect child and current placement. If placement has been disrupted, please explain why placement has disrupted.

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## **IV. Education**

21. Current/Last School: \_\_\_\_\_ Location: \_\_\_\_\_

22. Current/Last Grade: \_\_\_\_\_

23. Has child been classified as special needs? (Circle one) Yes No

If Yes, specify category: \_\_\_\_\_

24. IEP/504 Plan: (Circle one) Yes No

25. Check applicable school issues:

\_\_\_\_\_ Inconsistent school attendance \_\_\_\_\_ Poor Academic Progress

\_\_\_\_\_ Expulsion/Suspension \_\_\_\_\_ Truancy

\_\_\_\_\_ Behavior Problems \_\_\_\_\_ Other, Specify: \_\_\_\_\_

## **VI. Medical**

26. Current Medical Issues: \_\_\_\_\_

27. Allergies: \_\_\_\_\_

28. Date of Last Physical: \_\_\_\_\_ 65. Physician Name: \_\_\_\_\_

29. Date of Last Dental Exam: \_\_\_\_\_ 67. Dentist Name: \_\_\_\_\_

30. Name current medications: \_\_\_\_\_

Agency Signature: \_\_\_\_\_ Date: \_\_\_\_\_