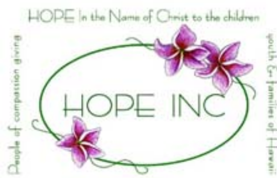

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REFERRAL FORM

Email or Fax

Social Worker:	Unit:	SW Ph#:	SW Cell/Pager#:
Name of Assistant:		Ass Ph#:	Date Referred:
Supervisor:		Sup. Ph#:	Fax#:
GAL:	Email:		
Therapist:	Email:		
Other Team-members:	Email:		
	Email:		
	Email:		

CHILD

Name: DOB: SS#:

Gender: ☐ Male ☐ Female	Type of Placement Needed: ☐ Foster ☐ Adoption
Current Foster Parents:	Ethnicity:
Address:	Legal Status: ☐ TFC ☐ PC In Appeal: ☐ YES ☐ NO
	Initial Date of DHS Placement Responsibility:
	Date of Permanent Custody:
	Contact Person (Therapeutic Program):
School:	Grade:
SPED: ☐ YES ☐ NO	Next IEP:
Metal Health Diagnosis:	
Medical Diagnosis:	

Birth Family and Significant Connections

Name	Visits		Who Coordinates Visits
1. Birth Father:	YES	NO	
2. Birth Mother:	YES	NO	
3. Siblings:	YES	NO	
4.	YES	NO	
5.	YES	NO	
6.	YES	NO	
7.	YES	NO	
8.	YES	NO	

CHILD'S HISTORY

1 Has youth had previous permanent placement? ☐YES ☐ NO ☐ UNK

2 Has this youth been a danger to him/herself or to other in the last 90 days? ☐YES ☐ NO ☐ UNK
- ☐ attempted suicide ☐ suicidal gestures ☐ suicidal ideation
- ☐ runaway ☐ puts self in dangerous situations
- ☐ sexually molested others (or attempted to)

3 Has youth experienced physical or sexual abuse or has he/she been exposed to violent behavior? ☐YES ☐ NO ☐ UNK

4 Does this youth have behaviors that are so difficult that maintaining him/her in his/her current living or educational situation in jeopardy? ☐YES ☐ NO ☐ UNK

5 Has the youth exhibited bizarre behavior or unusual behaviors in the last 90 days? ☐YES ☐ NO ☐ UNK
- ☐ fire setting ☐ cruelty to animals ☐ repetitive vocalizations
- ☐ hears voices or respond to internal ☐ repetitive body motion
- ☐other

6 Does the youth have problems with social adjustment and maintaining healthy relationships? ☐YES ☐ NO ☐ UNK

7 Does the youth have problems with personal care? ☐YES ☐ NO ☐ UNK
- ☐ eats or drinks substances that are not food
- ☐ enuretic during waking hours ☐ poor personal hygiene
- ☐ encopretic

8 Does this youth have significant functional impairment? ☐YES ☐ NO ☐ UNK

9 Does this youth have significant problems managing his/her feelings? ☐YES ☐ NO ☐ UNK
- ☐ physical fights ☐ cries inconsolably ☐ nightmares
- ☐withdrawn ☐excessive worries ☐ frequently sad or depressed
- ☐ restless or overactive

10 Does this youth have a history of psychiatric hospitalization? ☐YES ☐ NO ☐ UNK

11 Is this youth known to abuse alcohol and/or drugs? ☐YES ☐ NO ☐ UNK

12 Does the child have a religious preference? ☐YES ☐ NO ☐ UNK

Date of Review:

This referral is:

☐Accepted into:

☐Inappropriate: (reason)

☐In need of further information

To Review again on: