



HOPE INC
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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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Type of Placement Needed: <input type="checkbox"/> Foster <input type="checkbox"/> Adoption
Current Foster Parents:	Ethnicity:
Address:	Legal Status: <input type="checkbox"/> TFC <input type="checkbox"/> PC In Appeal: <input type="checkbox"/> YES <input type="checkbox"/> NO
	Initial Date of DHS Placement Responsibility:
	Date of Permanent Custody:
	Contact Person (Therapeutic Program):
School:	Grade:
SPED: <input type="checkbox"/> YES <input type="checkbox"/> 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?
 attempted suicide suicidal gestures suicidal ideation
 runaway puts self in dangerous situations
 sexually molested others (or attempted to) YES NO UNK
- 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?
 fire setting cruelty to animals repetitive vocalizations
 hears voices or respond to internal repetitive body motion
 other YES NO UNK
- 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?
 eats or drinks substances that are not food
 enuretic during waking hours poor personal hygiene
 encopretic YES NO UNK
- 8 Does this youth have significant functional impairment? YES NO UNK
- 9 Does this youth have significant problems managing his/her feelings?
 physical fights cries inconsolably nightmares
 withdrawn excessive worries frequently sad or depressed
 restless or overactive YES NO UNK
- 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: