

Referral Information – Please note a referral form MUST be completed for each child.

Date	Referral Time	Time frame by which home is needed (can be between 2 hours and 45 days):
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Referring Worker Information

Name	Email	Office Phone
City	County	Cell Phone

Ongoing Social Worker Case Manager (SWCM) Information – if applicable

Name	Email	Office Phone
City	County	Cell Phone

Referring Supervisor Information

Supervisor Name	Email	Cell Phone
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Ongoing Supervisor Information – if applicable

Supervisor Name	Email	Cell Phone
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Family Centered Service (FCS) Provider Information

FCS Name	Email	Cell Phone
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Child's Information at Time of Referral

First Name	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	State ID	Race
Pertinent Sibling information:		
Language	ICWA <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	

Address to start search for placement: (if different than parent/guardian address)			
City, State ZIP Code, County			
Parent/Guardian Address			
City	State	ZIP Code	County
Child's Current Address			
City	State	ZIP Code	County
Juvenile Court Involvement <input type="checkbox"/> Yes <input type="checkbox"/> No		Anticipated Length of Care	
Initial Removal Reason			
Placement Reason			
Financial County	Previous Foster family Placements <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Driver's License <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
School District	Current School	Grade	
Individual Education Plan (IEP) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Behavioral/IEP <input type="checkbox"/> Educational/IEP	Attends Place of Worship <input type="checkbox"/> Yes <input type="checkbox"/> No Denomination if known:	
Child Identifies as LGBTQ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA	Non-Binary/Transgender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Active <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA	
Please list any additional placements and reasons for discharge other than family foster care:			
Discussion of child's strengths:			
Discussion of child's needs:			
Child's special interests: (e.g. child likes to bake, do crafts, play outside etc.)			
Child's activities: (e.g. activities involved in at school, church, or neighborhood/community)			
Does child have siblings that will require continued contact? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Explain plan for continued contact:

Use Scale for each section below for those diagnosis that apply. If it does not apply, leave it blank.
Scale 2-5:

- 2 Child may have or has a very mild level of this behavior or special need.
- 3 Child has a mild to moderate level of this behavior or special need.
- 4 Child has a moderate to severe level of this behavior or special need.
- 5 Child has a very severe level of this behavior or special need.

Physical Health and Medical	Explanation or Discussion of Severity	Scale 2-5
Allergies to Medication		
Environmental Allergies		
Drug Affected		
Fetal Alcohol Syndrome		
Communicable Diseases		
Medically Fragile		
Physically Challenged		
Respiratory Impairment		
Special Dietary Needs		
Special Medical Needs		
Developmental Delays		

Mental Health Diagnosis	Explanation or Discussion of Severity i.e. how does the child display behaviors in the home setting	Scale 2-5
ADHD		
Other		
Autism Spectrum		
Trauma Affected		
Attachment Injuries		
Anxiety Disorder		
Depression Disorder		
Conduct Disorder		
Obsessive-Compulsive Disorder		
Oppositional Defiant Disorder		
Adjustment Disorder		
Post-Traumatic Stress Disorder		
Intellectual Disability		
Failure to Thrive		

Serious Behavioral Issues	Explanation or Discussion of Severity	Scale 2-5
Destructive Behavior		
Self-Harming Behavior		

Serious Behavioral Issues	Explanation or Discussion of Severity	Scale 2-
Suicide Ideation/Attempts		
Assaultive Behavior		
Encopresis or Enuresis Disorders		
Fire Setting Behaviors		
Pet Abuse/Fear of		
Sexually Reactive		
Sexual Offender or Perpetrator		
Substance or Alcohol Abuse		

Current Formal Information

Formal diagnosis:	Prescribed medication and what they are treating:
Prescribing Physician:	Current therapist:

Transportation Needs

<p>School</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:	<p>Activities</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:	<p>Health Care Specialist:</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:
<p>Family Interactions</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:	<p>Relatives/Friends</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:	<p>Extended Family Visits</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:
<p>Other</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Explanation:		

Risk Management

Characteristics of other children that this child should NOT be placed with:
Characteristics of potential match families that should not be considered for this child:
Current services in place:
Additional notes:

Form Prepared by	Date
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