



Referral Form for Placement

Complete as thoroughly as possible based on the information available.

Today's Date _____ Date Placement Needed: _____

Child Name:	PID #:
Date of Birth:	Age:

Primary Medical Needs	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Part of Sibling Group	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> List siblings name(s) and ages: Do you wish for this sibling group to be placed together? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Upcoming Visitations	Does the child have any upcoming visitation? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Please list date, time, duration and location of upcoming visits: Please note any 72-hour visitation scheduled (new removal) include date, time, duration and location:
Safe Baby/Baby Moses Case	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Level of Care (if applicable)	<input type="checkbox"/> Basic <input type="checkbox"/> Moderate <input type="checkbox"/> Specialized <input type="checkbox"/> Intense <input type="checkbox"/> Unknown
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White
Ethnicity	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

Behavioral

ADHD	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, list:		
Autism Spectrum Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Chemical dependency	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, list drug type:		
	If yes, list last known date of usage:		
Cruelty to animals	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Destruction of property	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Eating disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Enuresis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	How often:		
	Medication prescribed:		
Encopresis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	How often:		
	Medication prescribed:		
Fire starter	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Gang involvement	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>



History of chronic lying	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
History of theft	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Human trafficking victim	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Public masturbation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Running away- FROM PLACEMENT	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Self-mutilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, list date of last incident:		
Sexual aggression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Sexual victimization	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Sexually active	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Sibling or peer relations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Special dietary needs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, list dietary needs:		
Special medical needs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, list medical needs:		
Suicidal threats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, list last known threat:		
	If yes, list last known attempt:		
Truancy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Verbal aggression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Confidential illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Homicidal threats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Intellectual or developmental disability	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	IQ if known:		
LGBTQ	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>



Medically fragile	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Mental health needs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	Diagnosis, if known:		
Physically aggressive toward adults	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, list date of last incident:		
Physically aggressive toward peers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, list date of last incident:		
Physically challenged non-ambulatory	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Pregnant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, due date:		
Has a child	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
	If yes, age of child:		