Referral Form for Placement

Complete as thoroughly as possible based on the information available.

Date: _____

Child Name:		PID #:	
Date of Birth:		Age:	
Primary Worker:	Name: Phone:	Supervisor:	Name: Phone:
PD:	Name: Phone:	Covering worker (if applicable):	Name: Phone:

Primary Medical Needs:	Yes☐ No☐ Unknown ☐
Part of Sibling Group:	Yes☐ No☐ Unknown☐ List siblings name(s) and ages: Do you wish for this sibling group to be placed together? Yes☐ No☐ Unknown☐
Upcoming Visitations:	Does the child have any upcoming visitation? Yes☐ No☐ Unknown☐ 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☐ No☐ Unknown☐
Level of Care (if applicable)	☐ Basic ☐Moderate ☐ Specialized ☐ Intense ☐Unknown
Race	☐ American Indian or Alaska Native ☐Asian ☐African American ☐Native Hawaiian or Pacific Islander ☐ Other ☐White
Ethnicity	☐ Hispanic ☐ Non-Hispanic

Behavioral

ADHD	Yes☐	No☐	Unknown ☐
Allergies	Yes☐ No☐	Unknown ☐	
	If yes, list:		
Autism Spectrum Disorder	Yes☐	No☐	Unknown☐
Chemical dependency	Yes☐	No☐	Unknown☐
	If yes, list drug type:		
	If yes, list last known usage:		
Confidential illness	Yes☐	No☐	Unknown☐
Cruelty to animals	Yes☐	No☐	Unknown☐
Destruction of property	Yes☐	No☐	Unknown☐
Eating disorder	Yes☐	No☐	Unknown☐
Enuresis	Yes☐	No☐	Unknown☐
	How often:		
	Medication prescribed:		
Encopresis	Yes ☐	No☐	Unknown ☐
	How often:		
	Medication prescribed:		
Fire starter	Yes☐	No☐	Unknown☐
Gang involvement	Yes☐	No☐	Unknown☐
History of chronic lying	Yes☐	No☐	Unknown☐
History of theft	Yes☐	No☐	Unknown☐
Human trafficking victim	Yes☐	No☐	Unknown☐
Public masturbation	Yes☐	No☐	Unknown☐
Running away- FROM PLACEMENT	Yes☐	No☐	Unknown☐
Self-mutilation	Yes☐	No☐	Unknown☐
	If yes, list date of last incident:		
Sexual offender	Yes☐	No☐	Unknown☐
Sexually abused	Yes☐	No☐	Unknown☐
Sexually active	Yes☐	No☐	Unknown☐
Sibling or peer relations	Yes☐	No☐	Unknown☐
Special dietary needs	Yes☐	No☐	Unknown☐
	If yes, list dietary needs:		
Special medical needs	Yes☐	No☐ Unknown☐	
	If yes, list medical needs:		
Suicidal threats	Yes☐	No☐	Unknown☐
	If yes, list last known threat:		
	If yes, list last known attempt:		
Truancy	Yes☐	No☐	Unknown☐
Verbal aggression	Yes☐	No☐	Unknown☐
Homicidal threats	Yes☐	No☐	Unknown☐

Intellectual or developmental disability	Yes☐ No☐ Unknown☐ IQ if known:
LGBTQ	Yes☐ No☐ Unknown☐
Medically fragile	Yes☐ No☐ Unknown☐
Mental health issues	Yes☐ No☐ Unknown☐ Diagnosis, if known:
Physically aggressive to adults	Yes☐ No☐ Unknown☐ If yes, list date of last incident:
Physically aggressive to peers	Yes☐ No☐ Unknown☐ If yes, list date of last incident:
Physically challenged non-ambulatory	Yes☐ No☐ Unknown☐
Pregnant	Yes☐ No☐ Unknown☐ If yes, due date:
Has a child	Yes☐ No☐ Unknown☐ If yes, age of child: