

# CHILDREN'S SERVICES REFERRAL

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Date of Referral: \_\_\_\_\_ Date Placement is needed: \_\_\_\_\_

Type of Referral:  High Management  Moderate Management  
 Supervised Independent Living  Intensive Crisis Care  
 Residential Treatment Facility  Therapeutic Foster Care  
 Temporary De-escalation Care  Other:

Referring Agency:  DSS  DSS – IFCCS  DDSN  DJJ  Other:

If client is in DSS custody, has the ISCEDC team approved placement?  Yes  No

Case Manager's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## CLIENT INFORMATION

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Client's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Alias / Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Distinguishing Features (*i.e., scars, tattoos, birthmarks, etc.*): \_\_\_\_\_

Religious Affiliation:  Protestant  Catholic  Muslim  Jewish  None  Other: unknown

Hobbies: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ County of Legal Custody: \_\_\_\_\_

Medical Insurance Policy Number & Holder: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Legal Custodian: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Client's Strengths: (*Check all that apply*)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Strong Family Base              | <input type="checkbox"/> On Grade-Level            | <input type="checkbox"/> Average/Above IQ          |
| <input type="checkbox"/> Good Socialization Skills       | <input type="checkbox"/> Appropriate Reading Level | <input type="checkbox"/> Good Verbal Skills        |
| <input type="checkbox"/> Appropriate Coping Skills       | <input type="checkbox"/> Good Personal Hygiene     | <input type="checkbox"/> Appropriate Coping Skills |
| <input type="checkbox"/> Other: <input type="checkbox"/> |  |  |

Reason for Referral: \_\_\_\_\_

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Client's Current Placement: *(Check type of facility)*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High Management              | <input type="checkbox"/> Moderate Management            | <input type="checkbox"/> Supervised Independent Living |
| <input type="checkbox"/> Intensive Crisis Care        | <input type="checkbox"/> Residential Treatment Facility | <input type="checkbox"/> Therapeutic Foster Care       |
| <input type="checkbox"/> Temporary De-escalation Care | <input type="checkbox"/> Other:                         |  |

Number of Previous Placements:     0-3     4-6     7-10     More than 10

Placement History: *(Please list all placements including psychiatric hospitalizations.)*

| <u>Placement</u> | <u>From</u> | <u>To</u> | <u>Reason for Discharge</u> |
|------------------|-------------|-----------|-----------------------------|
|------------------|-------------|-----------|-----------------------------|

Current Behavioral Problems / Weaknesses: *(Check all that apply.)*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Aggressive (verbally)       | <input type="checkbox"/> Aggressive (physically)      | <input type="checkbox"/> Alcohol / drug abuse      |
| <input type="checkbox"/> Antisocial behavior         | <input type="checkbox"/> Anxiety                      | <input type="checkbox"/> Arson                     |
| <input type="checkbox"/> Bedwetting                  | <input type="checkbox"/> Below grade level            | <input type="checkbox"/> Cruelty to animals        |
| <input type="checkbox"/> Delusional                  | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Destroys property         |
| <input type="checkbox"/> Difficulty with authority   | <input type="checkbox"/> Developmentally delayed      | <input type="checkbox"/> Fire setting              |
| <input type="checkbox"/> Functionally illiterate     | <input type="checkbox"/> Eating disorder              | <input type="checkbox"/> Hyperactive               |
| <input type="checkbox"/> Impulsive                   | <input type="checkbox"/> Homeless                     | <input type="checkbox"/> Loss / grief difficulties |
| <input type="checkbox"/> Low IQ / mental retardation | <input type="checkbox"/> Low self-esteem              | <input type="checkbox"/> Oppositional / defiant    |
| <input type="checkbox"/> Parental neglect issues     | <input type="checkbox"/> Phobic reactions / behaviors | <input type="checkbox"/> Physical disability       |
| <input type="checkbox"/> Poor coping skills          | <input type="checkbox"/> Poor personal hygiene        | <input type="checkbox"/> Poor reality orientation  |
| <input type="checkbox"/> Poor social skills          | <input type="checkbox"/> Problems at school           | <input type="checkbox"/> Running away              |
| <input type="checkbox"/> Self-destructive behavior   | <input type="checkbox"/> Sexually acts out            | <input type="checkbox"/> Sexually provocative      |
| <input type="checkbox"/> Sibling related issues      | <input type="checkbox"/> Suicidal gestures            | <input type="checkbox"/> Suicidal ideations        |
| <input type="checkbox"/> Stealing                    | <input type="checkbox"/> Truancy                      | <input type="checkbox"/> Unruly / ungovernable     |
| <input type="checkbox"/> Other:                      | <input type="checkbox"/> Other:                       | <input type="checkbox"/> Other                     |

Client has been a victim of: *(Check all that apply.)*

- |  |                                     |  |                    |
|--|-------------------------------------|--|--------------------|
| <input type="checkbox"/> Neglect         | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated | Perpetrator: _____ |
| <input type="checkbox"/> Physical Abuse  | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated | Perpetrator: _____ |
| <input type="checkbox"/> Sexual Abuse    | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated | Perpetrator: _____ |
| <input type="checkbox"/> Emotional Abuse | <input type="checkbox"/> Allegation | <input type="checkbox"/> Substantiated | Perpetrator: _____ |

Client's DSM IV Diagnosis: *(Check all that apply.)*

| <u>Axis</u>                       | <u>Diagnosis Codes</u> | <u>Date Given</u> | <u>Source</u> |
|-----------------------------------|------------------------|-------------------|---------------|
| <input type="checkbox"/> Axis I   |                        |                   |               |
| <input type="checkbox"/> Axis II  |                        |                   |               |
| <input type="checkbox"/> Axis III |                        |                   |               |
| <input type="checkbox"/> Axis IV  |                        |                   |               |
| <input type="checkbox"/> Axis V   |                        |                   |               |

Client's Medications: *(List all current medications, dosages, and instructions.)*

| <u>Medication Name</u> | <u>Dosage</u> | <u>Instructions</u> | <u>Prescribed By</u> | <u>Date Prescribed</u> |
|------------------------|---------------|---------------------|----------------------|------------------------|
|------------------------|---------------|---------------------|----------------------|------------------------|

Client's Medical Conditions: *(Check all that apply. C = Current H = History of)*

|           |   |             |   |             |   |              |   |
|-----------|---|-------------|---|-------------|---|--------------|---|
| Anemia    | <input type="checkbox"/> C <input type="checkbox"/> H | Anorexia    | <input type="checkbox"/> C <input type="checkbox"/> H | Asthma      | <input type="checkbox"/> C <input type="checkbox"/> H | Bulimia      | <input type="checkbox"/> C <input type="checkbox"/> H |
| Burns     | <input type="checkbox"/> C <input type="checkbox"/> H | Chicken Pox | <input type="checkbox"/> C <input type="checkbox"/> H | Convulsions | <input type="checkbox"/> C <input type="checkbox"/> H | Eczema       | <input type="checkbox"/> C <input type="checkbox"/> H |
| Enuresis  | <input type="checkbox"/> C <input type="checkbox"/> H | Encopresis  | <input type="checkbox"/> C <input type="checkbox"/> H | Fainting    | <input type="checkbox"/> C <input type="checkbox"/> H | Hay Fever    | <input type="checkbox"/> C <input type="checkbox"/> H |
| Headaches | <input type="checkbox"/> C <input type="checkbox"/> H | HIV/AIDS    | <input type="checkbox"/> C <input type="checkbox"/> H | Lice        | <input type="checkbox"/> C <input type="checkbox"/> H | Measles      | <input type="checkbox"/> C <input type="checkbox"/> H |
| Mumps     | <input type="checkbox"/> C <input type="checkbox"/> H | Pink Eye    | <input type="checkbox"/> C <input type="checkbox"/> H | Ringworm    | <input type="checkbox"/> C <input type="checkbox"/> H | Seizures     | <input type="checkbox"/> C <input type="checkbox"/> H |
| Sinusitis | <input type="checkbox"/> C <input type="checkbox"/> H | Sore Throat | <input type="checkbox"/> C <input type="checkbox"/> H | STD(s)      | <input type="checkbox"/> C <input type="checkbox"/> H | Tuberculosis | <input type="checkbox"/> C <input type="checkbox"/> H |
| Other:    | <input type="checkbox"/> C <input type="checkbox"/> H | Other:      | <input type="checkbox"/> C <input type="checkbox"/> H | Other:      | <input type="checkbox"/> C <input type="checkbox"/> H | Other:       | <input type="checkbox"/> C <input type="checkbox"/> H |
| Other:    | <input type="checkbox"/> C <input type="checkbox"/> H | Other:      | <input type="checkbox"/> C <input type="checkbox"/> H | Other:      | <input type="checkbox"/> C <input type="checkbox"/> H | Other:       | <input type="checkbox"/> C <input type="checkbox"/> H |

Date of client's last physical exam: \_\_\_\_\_ Results: \_\_\_\_\_

Date of client's last dental exam: \_\_\_\_\_ Results: \_\_\_\_\_

Date of client's last eye exam: \_\_\_\_\_ Results: \_\_\_\_\_

Dental Appliances: Yes No

Orthodontic Appliances: Yes No

Contact Lenses: Yes No

Glasses: Yes No

Allergies: Yes No

List:

Special dietary needs: Yes No

List:

## FAMILY INFORMATION

### **Biological Mother**

Name: \_\_\_\_\_ Deceased: Yes No  
 Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Race: \_\_\_\_\_ Criminal Record: Yes No  
 Educational Level: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Parental Rights Terminated: Yes No Date: \_\_\_\_\_

### **Biological Father**

Name: \_\_\_\_\_ Deceased: Yes No  
 Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Race: \_\_\_\_\_ Criminal Record: Yes No  
 Educational Level: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Parental Rights Terminated: Yes No Date: \_\_\_\_\_

Biological parents are: Married Separated Divorced Other: never married

### **Siblings**

| Sibling Name | Age | Current Placement |
|--------------|-----|-------------------|
|              |     |                   |
|              |     |                   |
|              |     |                   |
|              |     |                   |

### **Approved Family Contact**

| Significant Family Member | Relationship to Client | Address | Phone Number | Type of Contact Allowed<br><i>(phone, letters, face-to-face, etc.)</i> |
|---------------------------|------------------------|---------|--------------|--|
|                           |                        |         |              |  |
|                           |                        |         |              |  |
|                           |                        |         |              |  |

### **Other Approved Contact**

| Name | Relationship to Client | Address | Phone Number | Type of Contact Allowed<br><i>(phone, letters, face-to-face, etc.)</i> |
|------|------------------------|---------|--------------|--|
|      |                        |         |              |  |

## **Home Visits / Furloughs**

Are there any special conditions/restrictions for home visits or furloughs? Yes No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

## **Family History**

There is a family history of: *(Check all that apply.)*

- |  |  |
|--|--|
| <input type="checkbox"/> Child Abuse / Neglect         | <input type="checkbox"/> Criminal Activity   |
| <input type="checkbox"/> Inappropriate Sexual Behavior | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Treatment Disruption          | <input type="checkbox"/> Other:              |

Brief summary of family history including information on education, behavior, development, adoption, psychosocial, legal (*arson, stealing, sexual, burglary, and assault*), parent's psychiatric history, etc.: Matthew entered foster care because his mother and her boyfriend went into DSS asking for help with a drug addiction. They were high at the time. Matthew has been in care for almost six years. Matthew's mother and mother's paramour have moved to Texas.

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## SCHOOL INFORMATION

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Name of Last School Enrolled: \_\_\_\_\_

Grade: \_\_\_\_\_

District: \_\_\_\_\_

Special Education Classification:

- Learning Disabled
- Emotionally Disturbed
- Educable Mentally Disabled
- Trainable Mentally Disabled
- Other Health Impairment
- Speech or Language Impairment
- Profoundly Mentally Disabled
- Hearing Impairment
- Visual Impairment
- Multiple Disabilities
- Orthopedic Impairment
- Deafness
- Deafness-Blindness
- Autism
- Traumatic Brain Injury
- None (Regular Education)

Delivery Model:

- Resource Room
- Self-Contained Classroom
- Itinerant
- Medical Homebound
- Home-based (special education required)
- Regular Education

Does the client have a current IEP?       Yes     No

Date: \_\_\_\_\_

Does the client have a Section 504 plan?       Yes     No

Date: \_\_\_\_\_

Does the client have a history of truancy?       Yes     No

Has the client ever been suspended?       Yes     No

Has the client ever been expelled?       Yes     No

If yes, explain: \_\_\_\_\_

If yes, when: \_\_\_\_\_

If yes, name of school district: \_\_\_\_\_

**IQ / Achievement / Adaptive Testing:**

| Name of Test | Date Administered | Administered By | Scores and Range |
|--------------|-------------------|-----------------|------------------|
|              |                   |                 |                  |
|              |                   |                 |                  |
|              |                   |                 |                  |

**Brief summary of emotional / behavioral functioning:** *(Findings from psychological assessments.)*

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## AGENCY / COURT INVOLVEMENT

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Agencies currently involved with client:

- CCRS   COC   DDSN   DJJ   DMH   DSS   DSS-IFCCS   Voc Rehab  
Other:

Has the client ever been to court? Yes No *(If yes, list type of court, reason, date, and outcome.)*

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Does the client have pending charges? Yes No *(If yes, list charges.)*

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Is placement court ordered? Yes No *(If yes, attach a copy of the court order.)*

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## TREATMENT GOALS

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Client's Goals:

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Family's Goals (if applicable):

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Agency's Goals:

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Educational Goals:

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## ADMISSION REQUIREMENTS CHECKLIST

*(TO BE FORWARDED IF CLIENT IS ACCEPTED FOR PLACEMENT)*

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The referring agency will make every reasonable effort to supply the items listed in the Admission Requirements Checklist if the client is accepted for placement. If more information than is provided in the Children's Services Referral Application is required to determine client eligibility for admission, the provider agency should request in writing the additional information from the referring agency.

| ADMISSION REQUIREMENTS CHECKLIST<br>(IF ACCEPTED FOR PLACEMENT)                         |  |
|---|--|
| Medical Exam  |  |
| Most Recent Treatment Plan  |  |
| Current Medicaid /Insurance Card  |  |
| Medical Necessity Form  |  |
| 254 Authorization Form  |  |
| Most Recent Psychological/Psychiatric Evaluation(s)                                     |  |
| Previous Placement Discharge Summary(ies)   |  |
| Individual Education Plan (if applicable)   |  |
| Copy of Birth Certificate   |  |
| Copy of Social Security Card  |  |
| Immunization Records  |  |
| Completed Consent Forms (Program should forward to referring agency prior to admission) |  |
| Copies of Court Orders  |  |
| Signed Homebound Form (if applicable)   |  |
| Pre-Admission Assessment (if applicable)  |  |

Signature of person making application: \_\_\_\_\_ Date: \_\_\_\_\_

Name of person making application: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Agency associated with, if applicable: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_