Family&Children FIRST COUNCIL

Addendum A

Service Coordination Referral Form

DO NOT LEAVE ANY BLANK SPACES. ALL REQUESTED INFORMATION MUST BE PROVIDED

Date of Referral: _____ County: _____

Child's Name: _____ DOB: _____ Gender: M F

Address: _____ City, State, Zip: _____

School District: _____ School Attending: _____ Grade: _____

Child's Diagnoses: _____

Father: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City, State, Zip: _____

Mother: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City, State, Zip: _____

Legal Custodian: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City, State, Zip: _____

Siblings in the home/ages: _____

_____

Referring Agency: _____ Person Referring: _____

Phone: _____ Fax: _____ Email: _____

Reason(s) for referral:

☐ Child is age 0-21 and has multiple needs.
☐ Child/family is unable to access needed services.
☐ Child/family is experiencing a problem with coordination of existing services.
☐ Child is at-risk of being removed from his/her home or school.
☐ Child has been emergently removed from his/her home.

Does the referred child have a Primary Care Physician? _____ YES NO _____

Presenting Issues/Safety Concerns: _____

	Check all that apply:	Providers/Agencies	Contact Number
	Children age 5 & under in the family?		
	History of Alcohol or Drug Abuse? □ Youth □ Parent		
	Involved in? □Juvenile Drug Court □ Family Drug Court		
	Mental Health Issues? □ Child □ Caregiver		
	Family/Child(ren) involved in counseling?		
	Physical/Sexual/Emotional Abuse Issues?		
	Domestic Violence Issues?		
	Placement Concerns? □Yes □No Foster/Relative Provider:		
	Housing Concerns?		
	Educational Concerns? □Truancy □SED □On IEP □Expulsion		
	Behavioral Concerns?		
	Child Protective Involvement? □Yes □No Caseworker:		
	Juvenile Court Involvement? □Yes □No Charges:		
	Is client Medicaid eligible? □Yes □No		
	Does this child currently have a Primary Care Physician? □Yes □No		