# CHILD WELFARE REFERRAL FORM

## REFERRAL SOURCE

Referral Date: _____ FSFN Case # _____ FSFN Person ID: _____ FSFN Case Type: Select FSFN Case Type

Person Referring: _____ Agency: _____ Service Center: _____

Phone: _____ Email: _____

Supervisor: _____ Phone: _____ Email: _____

## CLIENT INFORMATION

First: _____ Middle: _____ Last: _____

SSN: _____ DOB: _____ Gender: ☐ Female ☐ Male

Marital Status: _____ Race: _____ Ethnicity: _____

Client/Caregiver Phone: _____ Client/Caregiver Email: _____

Address: _____ City: _____ Zip: _____ County: _____

Current Caregiver: _____ Relationship: _____ Legal Guardian, if not Caregiver: _____

Language Preference: _____ Pregnant? ☐No ☐ Yes If yes, Date Due: _____

Medicaid Plan: _____ Medicaid #: _____ Other Health Insurance #: _____

Other Health Insurance Name: _____ Other Health Insurance Phone: _____

## PRESENTING PROBLEM

If you are requesting an **evaluation**, please be specific about what you hope to learn. If you are requesting a **service**, please list what issue(s) or symptom(s) you would like addressed or goals you wish to see accomplished and how it relates to case plan goal and needs of child/family.

## SERVICE REQUESTED

**Section I: Assessment and Evaluation Services**

☐Psychiatric Evaluation
☐Mental Health Assessment
☐Substance Abuse Assessment
☐Psychological Evaluation
☐Neuropsychological Evaluation
☐Psychological Evaluation with IQ and Achievement
☐Psychosexual Evaluation
☐Attachment/Bonding Assessment
☐Evaluation Addendum

**Section II: Therapy Services**

☐Mental Health Counseling Intake, to include Treatment Plan
☐Individual Therapy
☐Group Therapy
☐Family Therapy
☐Specialized Therapy (Type: Sexual Abuse, Play, Equine, etc.)
List Type: _____
☐Substance Abuse (Individual)
☐Substance Abuse (Group)
☐Therapeutic Supervised Visitation
☐Medication Management
☐Anger Management (Group)
☐Batterer's Intervention Program (BIP) - Intake, Asmt. & Orient.
☐Batterer's Intervention Program (Group)

**Section III: Additional Services**

☐Behavior Analyst Assessment
☐Behavior Analyst Sessions - ☐ BCBA or ☐ BCaBA
☐Mentoring - ☐ Traditional or ☐ Therapeutic
☐Parenting Group (>1 Participant/Class Setting)
☐Parent/Adolescent Coaching
☐Laboratory Testing - ☐ Substance Abuse or ☐ Paternity
☐Targeted Case Management
☐Translation Services
☐Tutoring
☐Medical Education Services (In Home) - ☐ RN or ☐ LPN
☐Personal Care/Respite Services
☐Intensive In Home Medical Services (RN or Higher)
☐Other: _____
_____
_____

## PROVIDER INFORMATION

Provider Name: _____ Phone: _____ Email: _____

***IMPORTANT* REFERRAL DOCUMENTATION TO FOLLOW (EMAIL TO PROVIDER) *IMPORTANT***

☐Family Functioning Assessment (FFA) Initial & Ongoing ☐ Shelter Order ☐ Case Plan ☐ Judicial Reviews ☐Education Records
☐Previous Evals. ☐Previous Treatment Records ☐CBHA ☐Other, List: _____

Collateral Contacts: Name: _____ Phone: _____ Relationship: _____
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## MENTAL HEALTH AND SUBSTANCE ABUSE HISTORY

Current Diagnosis(es): _____
Type of Drug(s) Using: _____
Date Drug Tested: _____ Results: ☐Positive ☐ Negative
Positive Results: ☐THC ☐AMP ☐MET ☐PCP ☐COC ☐OPI ☐Other, List:

| Type of Services | Current | Past | Provider/Program |
|---|---|---|---|
| Outpatient Counseling | | | |
| Medication (Mental Health) | | | |
| Inpatient Hospitalization/Detox/Baker Act | | | |
| Other, List: | | | |

**INFORMATION FOR TANF REFERRALS ONLY (REQUIRED FOR ADULTS WITH MH/SA SERVICES)**

Household Size (incl. participant): _____ # Adults: _____ # Children: _____

| Name | Age | Relationship |
|---|---|---|
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| | | |
| | | |
| | | |

Number of Children Living In: Home: _____ Foster Care: _____ With Relative: _____ With Friend: _____
Residential: _____ Shelter: _____ Homeless: _____ Other: _____ List Other: _____

**Requirements for Children Removed from Home:**

Active Case Plan Goal is Reunification: ☐Yes ☐ No **If no, then client is not eligible for TANF services
A Copy of Case Plan is Attached to Referral: ☐Yes ☐ No
If Case Plan is Not Available, Please Explain: _____

**TO BE COMPLETED BY ALL PROVIDERS**

Date Referral Received: _____ ☐Approved ☐ Denied Next Appt. Date: _____
Reason for Denial: ☐Income above Guidelines ☐Incomplete Information ☐Other (specify in comments)
Date Referral Receipt Notification Sent by Email Back to Referral Source AND referrals@cbccfl.org: _____
Comments: _____

Printed Name of Staff _____ Phone _____ Email _____

**PLEASE SEND COMPLETED ASSESSMENT(S) OR MONTHLY SERVICE SUMMARY REPORT(S) ONGOING TO REFERRAL SOURCE**