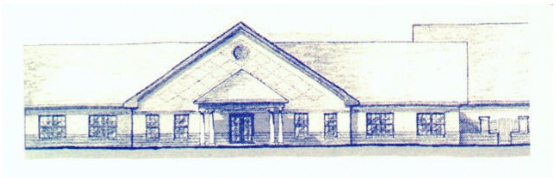


The Children's Aid Home Programs
of Somerset County, Inc.

REFERRAL FORM

Today's Date

Name of Person Completing Referral

CHILD INFORMATION

Child Last Name	First	MI	D.O.B.	Age	Sex ❑ M ❑ F

Address (Street Address, City, State, Zip Code)	County	Telephone Number(s)	SS Number
	Race		Place of Birth

Current School District / Address / Phone (if available)	Primary Language Spoken	Grade

Reason for Referral (Be specific – Use additional sheets if necessary)

❑ Physical Abuse	❑ Family Problems	❑ Eating Disorder	❑ Alcohol Abuse	❑ Probation Violation
❑ Sexual Abuse	❑ Neglect	❑ School Problems	❑ Other Drug Use	❑ Court Order
❑ Conduct Problems	❑ Suicidal Thoughts	❑ Depression	❑ Runaway	❑ Physical Aggression
❑ Fire Setting	❑ Other: (please describe in detail)			

Immediate Treatment Goals

Current Service Providers / Involved Parties (Use additional sheets if necessary.):

Name of Service Provider	Worker	Address (Street Address, City, State, Zip)	Dates of Placement	Type of Svc/Placement
1.				
2				
3.				
4.				
5.				

Previous Placements and / or Services (Use additional sheets if necessary.)

Name of Service Provider	Address (Street Address, City, State, Zip Code)	Telephone	Provider Type
1.			
2.			
3.			
4.			

MEDICAL INFORMATION

Child's Primary Care Physician	Address (Street Address, City, State, Zip Code)	Telephone

Is the child on medication? ❑ Yes ❑ No	Special Physical Health Care Concerns (e.g., allergies, physical problems, etc. Specify and attach information as appropriate)

Current Medications (name of medication, dosage, time of dosage, and prescribing physician)

INSURANCE INFORMATION (PLEASE ATTACH A COPY OF THE CHILD'S INSURANCE

Is child covered by insurance? ❑ Yes ❑ No	❑ MA/Access ❑ BC/BS ❑ UPMC ❑ Gateway	❑ Other (Specify)

Primary Physical Health Care Provider / Number(s):	Primary Behavioral Health Care Provider / Number(s):
Secondary Physical Health Care Provider / Number(s):	Secondary Behavioral Health Care Provider / Number(s):

PARENT INFORMATION

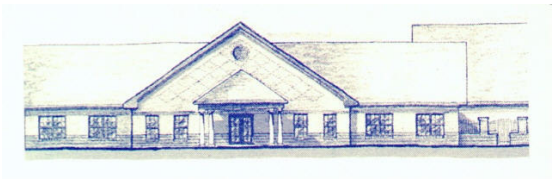
Biological Mother Last Name	First	Middle	Birth Date / /	Age
Address (Street Address, City, State, Zip Code)			Marital Status	Telephone
Biological Father Last Name	First	Middle	Birth Date / /	Age
Address (Street Address, City, State, Zip Code)			Marital Status	Telephone

CONTACT RESTRICTIONS:

❑ Contact Restricted (Provide Detail Below):	❑ Contact Permitted (Provide Detail Below):

PLEASE DO NOT WRITE BELOW THIS LINE (staff use only)

Efforts made to provide referral source with possible alternatives to placement:	❑ Accepted (reason): ❑ Denied (reason):



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Required Referral Information

Please provide the following prior to or upon placement of child:

1. Psychological/Psychiatric evaluations
2. Records from previous placements
3. Insurance information (card required for child placement)
4. Recent physician/dentist report
5. Immunization records
6. Medication
7. Family Service Plans / Permanency Plans / Court records / Voluntary Placement Agreement
8. Educational records
9. D/A evaluations
10. Birth Certificate
11. Hearing aids, glasses / contacts, etc. (if applicable)
12. Clothing
13. Notice of upcoming medical, dental, etc. appointments
14. History relevant to violent, fire setting, or sexually aggressive acts