INTAKE REFERRAL FORM

Date: ____________________

Authorized Representative: ____________________ Case No.: ____________________

Phone: ____________________ Fax: ____________________ Email: ____________________

Child's Name: ____________________ DOB: __________ Age: __________

Gender: ☐ Female ☐ Male Primary language spoken: ____________________ Other languages: ____________________

Ethnic Background: ____________________ Religious Preference: ____________________ Sexual Orientation Issues? ☐ Yes ☐ No

PLACEMENT

Current placement: ☐ Relative ☐ FFA ☐ Group Home Other: ____________________

Anticipated length of placement: ____________________

Current School: ____________________

Reason(s) for termination from previous placement(s)? ____________________

FAMILY

Mother: ____________________ Involvement? ☐ Yes ☐ No

Father: ____________________ Involvement? ☐ Yes ☐ No

Siblings: ____________________

Other Significant Adults/Children: ____________________

VISITATION? ☐ Yes ☐ No Needs Supervised Visits: ☐ Yes ☐ No How often? ____________________

Who does child visit? ____________________

Describe visits (location, special issues, etc.): ____________________

People not authorized to see child: ____________________

MEDICAL Medication? ☐ Yes ☐ No Medication name(s): ____________________

Medical Concerns: ____________________

THERAPY **In therapy?** ☐ Yes ☐ No ☐ Needs to be arranged

Therapist's Name: ____________________ Phone: ____________________

Agency: ____________________ Address: ____________________

EDUCATION Current IEP? ☐ Yes ☐ No (If yes, send copy with referral) IEP needs to be arranged? ☐ Yes ☐ No

Current School: ____________________ Grade: __________ District: ____________________

School Address: ____________________ Phone: ____________________

Special School Needs: ____________________

IDENTIFYING PROBLEMS

Please place a check mark in the first column for the child and check mark(s) in the second column for the parent(s)

	Child	Mother or Father	BEHAVIORAL ISSUES	Child	Mother or Father	LEGAL ISSUES	Child	Mother or Father
Substance Abuse	☐	☐ M ☐ F	Oppositional	☐	☐ M ☐ F	Theft	☐	☐ M ☐ F
Sexual Abuse	☐	☐ M ☐ F	Explosive Disorder	☐	☐ M ☐ F	Assault	☐	☐ M ☐ F
Suicidal Ideation	☐	☐ M ☐ F	Lack of Impulse Control	☐	☐ M ☐ F	Trespass	☐	☐ M ☐ F
Suicidal Gestures	☐	☐ M ☐ F	Attitude Problems	☐	☐ M ☐ F	Molest	☐	☐ M ☐ F
Self-injurious Behavior	☐	☐ M ☐ F	Assaultive	☐	☐ M ☐ F	Burglary	☐	☐ M ☐ F
Physically Abusive	☐	☐ M ☐ F	Verbally Abusive	☐	☐ M ☐ F	Weapons	☐	☐ M ☐ F
Physically Abused	☐	☐ M ☐ F	School Problems	☐	☐ M ☐ F	Vandalism	☐	☐ M ☐ F
Gang Affiliations	☐	☐ M ☐ F	Smoking	☐	☐ M ☐ F	Battery	☐	☐ M ☐ F
Mental Health Diagnosis	☐	☐ M ☐ F	Sexual Acting Out	☐	☐ M ☐ F	Arson	☐	☐ M ☐ F
Hospitalization	☐	☐ M ☐ F	Fire Setting	☐	☐ M ☐ F	Substance Abuse	☐	☐ M ☐ F
Health Problems	☐	☐ M ☐ F	Other:	☐	☐ M ☐ F	Other:	☐	☐ M ☐ F
Physical Limitations	☐	☐ M ☐ F		☐	☐ M ☐ F		☐	☐ M ☐ F
Enuresis	☐	☐ M ☐ F		☐	☐ M ☐ F		☐	☐ M ☐ F
Ecopresis	☐	☐ M ☐ F		☐	☐ M ☐ F		☐	☐ M ☐ F
Other:	☐	☐ M ☐ F		☐	☐ M ☐ F		☐	☐ M ☐ F

Please explain all checked boxes above:

What are the child's strengths, interests, talents, and hobbies?

Special Needs:

Special Transportation Needs:

Dangerous Propensities? ☐ **Yes** ☐ **No** **If yes, describe:**

Additional comments:

Authorized Representative: ______________________________ ________________

Signature Date

Please submit this referral to the Intake Coordinator
Fax to 559.435.2076

We will be in contact with you upon receipt/after review of this referral.
Thank You for your interest in our agency.