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| --- | --- | --- | --- |
| **Referral Date:** | Click or tap here to enter text. | **County of residence:** | Click or tap here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Primary Caregiver Name: | Click or tap here to enter text. | | Check box if self-referral | |
| Address:  *(Note Apt. or Unit #)* | Click or tap here to enter text. | |  | |
| City/Town: | Click or tap here to enter text. | **State & Zip Code:** | | Click or tap here to enter text. |
| Gender: | Click or tap here to enter text. | **Telephone:** | | Click or tap here to enter text. |
| Race/Ethnicity: | Click or tap here to enter text. | **Preferred Language:** | | Click or tap here to enter text. |

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| **Referral Source/Contact Information** | |
| **Social Service Staff** | DCP&P Caseworker/Supervisor, Office: Click or tap here to enter text.  Phone number & E-mail: Click or tap here to enter text.  Other: Click or tap here to enter text. |
| **Community** | Mental Health Care Provider: Click or tap here to enter text.  Pediatrician: Click or tap here to enter text.  School/ Childcare: Click or tap here to enter text.  Other community agency: Click or tap here to enter text. |
| **Obtained Verbal consent from the Parent/Caregiver** | |

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| **Children**  Last Name/ First Name | DOB/ Age | Gender | Race/Ethnicity | Relationship to Primary Caregiver |
| Click or tap here to enter text. | / |  |  |  |
| Click or tap here to enter text. | / |  |  |  |
| Click or tap here to enter text. | / |  |  |  |
| Click or tap here to enter text. | / |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| **Other Adults**  Last Name/ First Name | DOB/ Age | Gender | Race/Ethnicity | Relationship to primary caregiver | In home  Y/N? |
| Click or tap here to enter text. | / |  |  |  |  |
| Click or tap here to enter text. | / |  |  |  |  |
| Click or tap here to enter text. | / |  |  |  |  |

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| **Reason for referral and/or desired outcome:**  Click or tap here to enter text. | | | | | |
|  | | | | | |
| *For Internal Office Use Only:* | | | | | |
| **Reviewed by Gatekeeper:** |  | |  |  |  |
| *Name* | | *Title* | *Telephone* | *State E-mail* |
| Individual and Family Assessment (Case Plan) | | Attached | | | |
| Disposition | | Family declined Date: | | | Referral accepted Date: |
|  | | | | | Referral denied Date: |