



DATE OF REFERRAL:

REQUEST FOR SERVICE

Date of receipt:
Child First Staff Initials:

CHILD INFORMATION:

Name (First / Last): _____ **DOB:** _____ **Age:** _____

Gender: M F unknown

Racial Origin: American Indian/Alaskan Native Asian Black/African-American
(check one) Native Hawaiian/Other Pacific Islander White Other

Hispanic Origin: Hispanic Non-Hispanic

CAREGIVER INFORMATION – Person(s) with whom child resides:

Name: _____ **Age:** _____ **Gender:** Male Female
(First, Last)

Relation to child: biological parent adoptive parent foster parent relative other

Is this the child's legal guardian? Y N unknown **If no, name of legal guardian:** _____

Street address: _____ **Town/State/Zip:** _____

Phone: (check preferred #) Home : _____ Mobile : _____ Work : _____

Best times to contact: 7-9am 9-12pm 12-5pm 6-9pm **Email address:** _____

Days & Hours available for services: M T W Th F // 8 am – noon noon – 4 pm 4-7 pm

Is English spoken fluently by caregiver/guardian? yes no unknown **Primary language:** _____

Do you have caregiver's permission to make referral? yes no **If yes,** written verbal both

Has family previously been served by Child First? yes no unknown **If yes, when?** _____

Does child/family have history of DSS involvement? none yes, present yes, past unknown
If yes: CPS Foster Care unknown **Name of Child Placement Agency:** _____

REFERRAL SOURCE INFORMATION

Name: _____ **Relation to caregiver/guardian:** _____ **Name of agency:** _____ **Position:** _____

Street address: _____

Telephone: **Office:** _____ **Mobile:** _____ **Fax:** _____

Best times to contact: 7-9am 9-12pm 12-5pm 6-9pm **Email address:** _____

Type of Referral Source: Caregiver self-referral Relative

<input type="checkbox"/> Birth to Three	<input type="checkbox"/> Family resource & support center	<input type="checkbox"/> Shelter - family
<input type="checkbox"/> Court personnel	<input type="checkbox"/> Health Department	<input type="checkbox"/> Substance abuse program
<input type="checkbox"/> Dept. of Social Services (DSS)	<input type="checkbox"/> Health provider – adult	<input type="checkbox"/> Other
<input type="checkbox"/> DSS – Home-based service	<input type="checkbox"/> Health provider – pediatric	
<input type="checkbox"/> Children's Developmental Services Agency	<input type="checkbox"/> Home visiting (Nurturing Family, Triple P, PAT, NFP)	
<input type="checkbox"/> LME/MCO – DMH/DD/SAS	<input type="checkbox"/> Hospital – Emergency Room (ER)	
<input type="checkbox"/> Domestic violence agency or shelter	<input type="checkbox"/> Hospital – Obstetrics	
<input type="checkbox"/> Early childhood education/childcare	<input type="checkbox"/> Mental health provider - adult	
<input type="checkbox"/> Emergency Mobile Psychiatric Service (Mobile Crisis)	<input type="checkbox"/> Mental health provider - child	
<input type="checkbox"/> Faith based organization	<input type="checkbox"/> School System	

REFERRAL INFORMATION

Please describe the concerns that have led to this referral: *Please also indicate if referral is urgent and why.*

If DSS referral, please indicate status and goals.

Reasons for Referral: (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Basic needs (e.g., housing, heat, food, TANF, SNAP, Medicaid) | <input type="checkbox"/> Child abuse/neglect | <input type="checkbox"/> Parent/caregiver mental health |
| <input type="checkbox"/> Child developmental/educational concerns | <input type="checkbox"/> Risk of child out-of-home placement | <input type="checkbox"/> Parent/caregiver substance abuse |
| <input type="checkbox"/> Child behavioral/emotional concerns | <input type="checkbox"/> Risk of child expulsion from school | <input type="checkbox"/> Parent support and education needs |
| <input type="checkbox"/> Child exposure to violence | <input type="checkbox"/> Risk of family eviction | <input type="checkbox"/> Service coordination needs |
| | <input type="checkbox"/> Major child/family health concerns | <input type="checkbox"/> Other (please specify): |

Other Services/Agencies Currently Involved with Child/Family: (Check and circle program if appropriate)

- | | | |
|---|--|--|
| <input type="checkbox"/> Birth to Three | <input type="checkbox"/> Family resource & support center | <input type="checkbox"/> Shelter - family |
| <input type="checkbox"/> Court personnel | <input type="checkbox"/> Health Department | <input type="checkbox"/> Substance abuse program |
| <input type="checkbox"/> Dept. of Social Services (DSS) | <input type="checkbox"/> Health provider – adult | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> DSS – Home-based service | <input type="checkbox"/> Health provider – pediatric | |
| <input type="checkbox"/> Children’s Developmental Services Agency | <input type="checkbox"/> Home visiting (Nurturing Family, Triple P, PAT,NFP) | |
| <input type="checkbox"/> LME/MCO – DMH/DD/SAS | <input type="checkbox"/> Hospital – Emergency Room (ER) | |
| <input type="checkbox"/> Domestic violence agency or shelter | <input type="checkbox"/> Hospital – Obstetrics | |
| <input type="checkbox"/> Early childhood education/childcare | <input type="checkbox"/> Mental health provider - adult | |
| <input type="checkbox"/> Emergency Mobile Psychiatric Service (Mobile Crisis) | <input type="checkbox"/> Mental health provider - child | |
| <input type="checkbox"/> Faith based organization | <input type="checkbox"/> School System | |

I _____, legal guardian of _____, give permission for this referral to be sent to the Child First affiliate agency _____ and for information to be sent to the Child First National Program Office. I understand that I will be contacted by the Child First affiliate agency directly to learn more about Child First and if it is an appropriate service for my child and my family.

Legal guardian signature: _____ Date: _____

Referrant signature: _____ Dare: _____

PLEASE RETURN TO: Fax completed referral forms to 910-202-5772 (Attention: Child First). Cases may be staffed with Child First Supervisors Samantha Daniel 910-515-8508 or Jessica Canavan 910-833-4162.
PLEASE ATTACH THE CHILD FIRST CONSENT FOR SERVICES.