



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: \_\_\_\_\_ DOB: \_\_\_\_\_ 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 Assistant Director CBFS, Jessica Canavan at 910-833-4162 or Child First Supervisors at 910-202-3155.