Allen County Family and Children First Council

Intersystems Service Coordination

**REFERRAL FORM**

**Submit completed form by Email to CENNEKING@ALLENCOUNTYOHIO.COM or FAX to 419-224-0183. Questions? Call 419-223- 8563**

**Date of Referral:** Click or tap to enter a date.

**FAMILY INFORMATION**

**Parent/Guardian’s Name:** Click or tap here to enter text.

**Street Address:** Click or tap here to enter text.

**City, State, Zip:** Click or tap here to enter text.

**Phone Number:** Click or tap here to enter text. **Alternate Phone:** Click or tap here to enter text.

**Email Address:** Click or tap here to enter text.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Referred Child**  | **Birth Date** | **Social Security #** | **Grade Level** | **Gender** | **Race** |
| Click or tap here to enter text. |   |  |  |  |  |
| **Name of Adults living in the home**  |  | **Relationship to Children** |
| Click or tap here to enter text. |  |  |
| Click or tap here to enter text. |  |  |
| Click or tap here to enter text. |  |  |
| **Names of Other Children living in the home** | **Birth Date** |  |  |  |  |
| Click or tap here to enter text. |  |  |  |  |  |
| Click or tap here to enter text. |  |  |  |  |  |
| Click or tap here to enter text. |  |  |  |  |  |

**REFERRED BY:**

**Name:** Click or tap here to enter text.

**Name of Organization (if applicable):** Click or tap here to enter text.

**Phone Number:** Click or tap here to enter text. **Email:** Click or tap here to enter text.

**Is an agency RELEASE OF INFORMATION FORM included?** [ ] **Yes** [ ] **No**

**Is the family aware of the referral?** [ ]  Yes [ ] No

**Is the child/family situation** [ ] **Chronic or** [ ] **a Crisis?** (Mark both if applicable)

**Reason for Referral: (check all that apply)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Child facing out of home placement | Child exhibiting behavior issues at school | Child exhibiting behavior issues at home | Family Crisis / Conflict | Legal charges pending / filed on the child. |
|[ ] [ ] [ ] [ ] [ ]

**Current System Involvement: (**check all that apply and enter System Contact name**)**

|  |  |  |
| --- | --- | --- |
|[ ]  Juvenile Court/ODYS |[ ]  ESC- IEP/ Special Ed or Alternative School.  |[ ]  Board of DD |
|[ ]  Job & Family ServicesMedicaid – Food Stamps (circle) |[ ]  School |[ ]  Head Start/PK |
|[ ]  Children Services |[ ]  Health / Medical |[ ]  Help Me Grow/EI |
|[ ]  Mental Health  |[ ]  Other –  |  |  |

**Known Presenting Risks or Needs** (Check all that apply)

|  |  |  |
| --- | --- | --- |
|[ ]  Suicidal Ideations, Gestures, Attempts |[ ]  Suspended, Expelled, Truancy, or Dropped Out of School |[ ]  Lack of Caregiver Supervision |
|[ ]  Self-Injurious Behavior |[ ]  Educational Disabilities |[ ]  Parent w/ Drug or Alcohol Problems |
|[ ]  Aggressive Behaviors toward others, Animals, Property, etc. |[ ]  Special Education |[ ]  Parent with Mental Illness or Developmental Delay |
|[ ]  Fire-setting  |[ ]  Autism |[ ]  Parent w/ Chronic Illness  |
|[ ]  Victimization: Physical, Emotional, Sexual, Neglect |[ ]  Developmental Disability |[ ]  Suspected/Substantiated Child Abuse |
|[ ]  Hears Voices – Sees Things |[ ]  Eating Disorder |[ ]  Unrestricted Internet Access |
|[ ]  Sexual Acting Out |[ ]  Chronic Illness/Condition |[ ]  Childcare for children with special needs |
|[ ]  Impulsive Behavior |[ ]  Poverty |[ ]  No Primary Care Physician |
|[ ]  Depression |[ ]  Unruly or Delinquent |[ ]  Violence in Home |
|[ ]  Youth uses Drugs or Alcohol |[ ]  Currently Placed out of home |  |  |

**Brief Summary of Presenting Problems:** (Please include details of needs, current diagnoses and medications, if known)