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 Services  Medicaid – 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)