

## Referral Information Sheet

Client Name: \_\_\_\_\_ Referral Agency/Region: \_\_\_\_\_

Referral Date: \_\_\_\_\_ Level of Care Referred to: \_\_\_\_\_ Current Placement: \_\_\_\_\_

Client DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Client SS #: \_\_\_\_\_ Race: \_\_\_\_\_

IQ Scores: FS: \_\_\_\_\_ V: \_\_\_\_\_ P: \_\_\_\_\_ Adaptive Behavior Functioning Score(s): \_\_\_\_\_

DX: Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_ Medications: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

Permanency Goal: \_\_\_\_\_ Parental Involvement? : \_\_\_\_\_

Date of last Psychological Evaluation: \_\_\_\_\_ Date of last Social History: \_\_\_\_\_

Client's Strengths: \_\_\_\_\_

Special Needs/Concerns: \_\_\_\_\_

Brief History: \_\_\_\_\_

Preferred Area of Placement (if applicable): \_\_\_\_\_

DCS Worker Name, Address, Phone (for state referrals):	Parent(s) Name, Address, Phone (if applicable)
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Other Comments: \_\_\_\_\_