

LOGAN COUNTY Child & Family Team REFERRAL FORM

Type of Referral: Informal CFT
 Formal CFT
 Consultation

Date of Referral: _____

Demographics

Identified Child Name: _____ DOB: _____
 Sibling 1: _____ DOB: _____
 Sibling 2: _____ DOB: _____
 Sibling 3: _____ DOB: _____
 Sibling 4: _____ DOB: _____

Caregiver Name(s): _____ Relationship to child: _____
 Address: _____ Phone: _____
 _____ Email: _____

Custodian of Child: _____ Parent Name(s) if different from caregiver: _____
 School District of Residence: _____ School of Attendance: _____

Referral Source

Name: _____ Agency: _____
 Phone Number: _____ Email Address: _____

REASON FOR REFERRAL: _____

Areas of Need (Check all that apply)

- Developmental Disabilities
 Child Abuse
 Unruly
 Physical Health
 Special Ed
 Mental Health
 Child Neglect
 Delinquent
 Alcohol/Drug
 Poverty

System Involvement

System	Organization Name	Worker Name	Individual(s) Served	Service Provided
Alcohol/Drug				
Children Services				
Child Support Enforcement				
Developmental Disabilities				
Family Court				
Housing				
Job & Family Services				
Mental Health				
Other:				

FOR FCFC USE ONLY

Triage Review Date: _____ Outcome: Level 1 I & R
 Level 2+ Informal CFT
 Level 3+ Formal CFT
 Date Referral Received: _____
 Date Referral Source Notified: _____ How they were contacted: _____ Staff initials _____ Database: _____