

LOGAN COUNTY Child & Family Team REFERRAL FORM

Type of Referral: Informal CFT (team facilitated by agency worker)
 Formal CFT (team facilitated by FCFC worker)
 Consultation (not sure who will facilitate team)

Date of Referral: _____

Demographics

Check those multi-need children from this household being referred (note: exchange of information will be needed for each child)

Child 1:	DOB: _____	School: _____	Gender: _____	Race: _____
Child 2:	DOB: _____	School: _____	Gender: _____	Race: _____
Child 3:	DOB: _____	School: _____	Gender: _____	Race: _____
Child 4:	DOB: _____	School: _____	Gender: _____	Race: _____
Child 5:	DOB: _____	School: _____	Gender: _____	Race: _____

Caregiver Name(s): _____ Parent Name(s) if different: _____
 Address: _____ Address: _____
 Phone: _____ Email: _____ Phone: _____
 Relationship to child(ren): _____ Custodian of Child(ren): _____

Referral Source

Name: _____ Agency: _____
 Phone Number: _____ Email Address: _____
 REASON FOR REFERRAL:

Areas of Need

put "child number" as outlined above for needs of each referred Child

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

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