REFERRAL FORM

PREMIER
THERAPEUTIC FOSTER CARE

☐FAPT/FAST ☐Court Ordered ☐Agency Placement

Name of Caller _____ Agency _____

Date _____ Phone # _____

Fax # _____ Email _____

Name of Child _____ DOB _____

Race _____ Religion _____

Language _____

Services Requested ☐ Respite ☐ Emergency respite ☐ TFC

Reason for referral

_____

_____

_____

Strengths

_____

_____

_____

_____

Weaknesses

_____

_____

_____

_____

School (location, grade, adjustment, IEP)

_____

_____

Therapy (where, how often)

_____

_____

Can child change schools?
YES ☐ NO ☐ N/A ☐

Can child change therapist?
YES ☐ NO ☐ N/A ☐

Diagnosis

_____

_____

Medication

_____

_____

History of sexual abuse	YES ☐	NO☐
History of sexual acting out	YES ☐	NO☐
History of physical abuse	YES ☐	NO☐
History of physical aggression	YES ☐	NO☐
History of verbal aggression	YES ☐	NO☐
History of neglect	YES ☐	NO☐

Placement History

_____

_____

Family/Sibling Visits (when, where)

_____

_____

Medical/Health Issues

_____

_____

Current Health Status

_____

_____

Type of Family needed

☐ AA ☐ Hispanic ☐ Caucasian ☐ N/A

☐ Single ☐ 2 parent ☐ Pets ok

☐ Younger children ☐ Older children No other children

Services needed from ACFS

_____

_____

Staffing Attendees

_____

Date of Staffing

_____

Meets Criteria YES ☐ NO ☐

Placed YES ☐ NO ☐

Placement Date

_____

Reasons placed/not placed

_____

Families considered

_____

Date families contacted

_____

PTFC signature/title

_____

Notes

Signature/Title

Date