COORDINATED CARE

Post Adoption/Kinship Care Connections REFERRAL FORM

General Information:

Date of Referral: _____

Child's Name: _____ DOB: _____

Sex: ☐ Male ☐ Female Race: _____ Declined to Specify: ☐

Parent/Guardian' Name: _____

Address: _____

Home Phone: _____

School: _____ Grade: _____

When/ Where Adopted: _____

Past or Current Behavior Concerns (i.e. behaviors, diagnoses, trauma, family dynamics, environment, etc.):

Background Information:

Abuse/Neglect: _____ Domestic Violence: _____

Youth Substance Abuse: _____ Family Substance Abuse: _____

School/Educational Placement: _____ Hospitalizations: _____

School Behavior: _____ Living in home: _____

Service Providers Involved:

Children Services: _____ Phone: _____

Juvenile Court: _____ Phone: _____

DD: _____ Phone: _____

Mental Health Provider: _____ Phone: _____

Other (agencies/school): _____ Phone: _____

Referred By: _____ Phone: _____

Office Use Only:

Date Referral Received/Reviewed: _____

Action Taken: _____

Outcome: _____

Referral Sources Notified: ☐ Yes ☐ No Date: _____

How? ☐ Verbal ☐ Fax ☐ Email ☐ Letter

Referrals may be sent to Kevin Stevens, kevin.stevens@warrencountyesc.com or fax (513)695-2961 or mail to Warren County ESC, Attn: Coordinated Care, 1879 Deerfield Rd., Lebanon, OH 45036.

Additional Comments:

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