For ECI Office Use Only:
Date Received: _____ Date of EVS Check: _____ Date Assigned: _____

everychildinc.
Family Ever After

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Family Focused Solution Based Services Referral Form

In order to process referrals in the timeliest manner, please be sure to fill out ALL areas of this form, PRINTING CLEARLY. Referrals with incomplete/insufficient information will be returned to the referral source for completion. ALL information is necessary to best connect the family with the appropriate service.

Referral Agency:	**Contact Person:**	**Phone/E-mail:**
Date Referral is Sent:		
Is the family aware that this referral is being made?		

Consumer Name (First, Last):	
Address:	**Phone:**
DOB:	**SSN:**
Race:	**Gender:**
CCBHO/MA#: (may be left blank if DOB and SSN are provided)	

LEAVE THIS SECTION BLANK FOR ADULT REFERRALS	
Legal Guardian(s): **Relationship to Consumer:**	**Address: (if different from Consumer)** **Phone number(s):**
Biological Mother:	**Address: (If different from above)** **Phone:**
Biological Father:	**Address: (If different from above)** **Phone:**

LIST ALL OTHERS LIVING IN THE HOME

Name (First & Last)	Age	Relationship to Consumer

School/ District (child clients):	**Employment (adult clients):**
Current Grade (child clients):	**Highest Level of Education (adult clients):**
Educational Placement (504,IEP):	
Additional information:	

Mental Health Diagnosis (suspected, current) Family Focused clients MUST have either a suspected or confirmed mental health diagnosis. If there is no current confirmed diagnosis, please specify what the suspected diagnosis may be. DO NOT LEAVE BLANK.
Physical Health Concerns (including D&A concerns for the referred person):

PCP:	**Address:**	**Phone Number:** **Fax Number:**
Psychiatrist/Psychologist (if applicable):	**Address:**	**Phone Number:** **Fax Number:**

Is there a risk of out of home placement for the REFERRED CHILD or any child in the care of a REFERRED ADULT? Explain:

Is this child currently in foster care?
Please list foster care history:

Symptom Checklist:

◯ Sexually acting out	◯ Theft	◯ Truancy/ School Refusal
◯ Anxiety	◯ Criminal Mischief	◯ Property Destruction
◯ Depression	◯ Arson	◯ Use of Alcohol
◯ Hyperactivity/ Impulsivity	◯ Criminal Conspiracy	◯ Use of Drugs
◯ SI	◯ Vandalism	◯ Runaway
◯ HI	◯ Simple Assault	◯ Curfew Violations
◯ SIB	◯ Aggravated Assault	◯ Verbal Aggression
◯ Delinquent peer group	◯ Probation Violations	◯ Physical Aggression
◯ Cognitive/ Developmental	◯ Trauma	◯ Family Relational Issues

Referral Concerns:

Include CURRENT symptoms for the referred child or adult. Please identify when these concerns first began and the duration and frequency of symptoms. Please comment on family/community interactions, behavioral concerns, etc. Identify what specific areas of support the Family Focused team is being requested to address:

Previous and Current Mental Health Treatment	Dates of Service	Facility/ Provider
◯ Outpatient		
◯ Partial		
◯ BHRSCA (wraparound)		
◯ Family-Based/ Focused		
◯ Psychiatric hospitalization		
◯ Residential Treatment Facility		
◯ CM/ SC		
◯ Other (specify)		

Current OCYF Involvement: Y / N	**Contact:** **Phone:**
Current JPO Involvement: Y / N	**Contact:** **Phone:**