FamilyWise

# PROGRAM REFERRAL FORM

Please attach a copy of the Release of Information form signed by the client to this refferral when applicable.

| Date of referral: | |
|---|---|

| Client Information | |
|---|---|
| Client Name: | |
| Client Address: | |
| | |
| Client County: | |
| Client Phone Number(s): | |
| | |
| Client E-mail: | |
| Client Birth Date: | |
| Client Gender: | |
| Client Ethnicity: | |
| Client Marital Status: | |

| Referring Party Information | |
|---|---|
| Referring Party Name: | |
| Referring Party Address: | |
| | |
| | |
| Referring Party Agency: | |
| Referring Party Phone Number(s): | |
| | |
| Referring Party E-mail: | |

| SERVICES REQUESTED (Check as many as apply) |
|---|
| Adult Parent Education:<br>Connections Group _____<br>In-Home Parenting _____ |
| Behavioral Health Services:<br>Parenting Assessment _____ |
| Next Phase Youth Services:<br>Teen Parenting _____<br>Independent Living Skill _____<br>Bright Beginnings _____ |
| Supervised Parenting:<br>Center-Based _____<br>In-Home _____<br>Monitored Visits _____<br>Safe Exchange Services _____ |

FamilyWise Services

FamilyWiseServices.org

MAIN OFFICE

3036 University Avenue SE
Minneapolis, MN 55414
P. 612.617.0191 F. 612.617.0193

281 Maria Avenue
St. Paul, MN 55106
P. 651.774.4990 F. 651.774.3652

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| Please state reason for referral: |
|---|
| |

| Child(ren) Information | | | | |
|---|---|---|---|---|
| Name(s): | D.O.B.(s): | Gender(s): | Ethnicit(y/ies): | Placement(s): (ex. foster care, etc.) |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Medical / Mental Health Information | |
|---|---|
| Mental Health Diagnoses: | |
| Medication: | |
| Chemical Dependency Issues: | |

| FINANCIAL SUPPORT (Check as many as apply) | |
|---|---|
| Receiving MFIP: _____ $: _____ | Receiving GA: _____ $: _____ |
| Receiving SSI: _____ $: _____ | Income: _____ $: _____ |

| LEGAL / LIVING SITUATION (Check as many as apply) | | |
|---|---|---|
| On probation: _____ | CPS Case Open: _____ | Out of Home Placement: (ex. foster care, etc.) _____ |
| On Parole: _____ | Halfway House: _____ | |
| In jail: _____ | Residential Treatment: _____ | Independent: _____ |
| In Workhouse: _____ | Transitional Housing: _____ | Other: _____ |

| Involvement with County Systems and Other Agencies (Check as many as apply) | |
|---|---|
| Criminal Justice: _____ | Family Court: _____ |
| Child Protection (CPS): _____ | Assist. Program through State: _____ |
| Chemical Dependency Program: _____ | Other: _____ |

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| CONTACTS (Indicate as many as apply) | |
|---|---|
| Child Protection Worker Name: | |
| Child Protection Worker Address: | |
| Child Protection Worker Phone #(s): | |
| Child Protection Worker E-mail: | |
| Probation Officer Name: | |
| Probation Officer Address: | |
| Probation Officer Phone #(s): | |
| Probation Officer E-mail: | |
| MFIP Worker Name: | |
| MFIP Worker Address: | |
| MFIP Worker Phone #(s): | |
| MFIP Worker E-mail: | |
| Case Manager/Social Worker Name: | |
| Case Manager/Social Worker Address: | |
| Case Manager/Social Worker Phone #(s): | |
| Case Manager/Social Worker E-mail: | |
| Individual Therapist Name: | |
| Individual Therapist Address: | |
| Individual Therapist Phone #(s): | |
| Individual Therapist E-mail: | |
| Other (please indicate) Name: | |
| Other (please indicate) Address: | |
| Other (please indicate) Phone #(s): | |
| Other (please indicate) E-mail: | |

| COLLATERAL INFORMATION (Please Check if Attached) | | |
|---|---|---|
| Parenting Assessment: ____ | CPS Case Plan: ____ | Court Hearing Report: ____ |
| Psychological Evaluation: ____ | Pre-Sentence Investigation: ____ | Other: ____ |

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