



CARES Institute

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REFERRAL FORM

revised 10/26/07

Date of Referral: _____

Spirit Case ID # _____

Case #: _____

Spirit Person ID # _____

(For Prosecutor's Office)

(For DYFS)

SERVICES BEING REQUESTED:

TYPE OF MEDICAL EXAM: Alleged Sexual Abuse Alleged Physical Abuse Alleged Neglect/
Failure to Thrive
 Record Review Other Medical: _____ CHEC Evaluation

TYPE OF MENTAL HEALTH SERVICES: Psychological Evaluation Psychiatric Evaluation
 Individual Therapy Group Therapy (If eligible)

PATIENT INFORMATION:

Child's Name: _____ Age: _____ DOB: _____

GENDER: Female Male

ETHNICITY: African – American Hispanic Asian – Pacific Caucasian/White
 Biracial: (Specify): _____

REFERRAL INFORMATION:

Referent: _____ **Phone #:** _____ **Cell:** _____

Supervisor: _____ **Phone #:** _____

Agency: DYFS ARC Prosecutor's Office

Professional (Medical, Mental Health, Legal) Hospital (Name) _____

Family Member (Specify): _____

Other (Specify): _____

County or DYFS Office in which referral originated:

DYFS Camden North DYFS Gloucester West DYFS Burlington East Atlantic Cumberland
 DYFS Camden Central DYFS Gloucester East DYFS Cumberland West Camden Gloucester
 DYFS Camden South DYFS Burlington West DYFS Cumberland East Cape May Salem
 DYFS Camden East Other (Please Specify): _____

Address of Referral Source: _____

Phone Number: () _____ **E-mail:** _____

BILLING INFORMATION:

DYFS SAR

VCCB Claim Number: _____ Date: _____

Medicaid Number: _____ Effective Date: _____

Other (e.g. Insurance, etc.) Please Specify: _____

CHILD'S CURRENT PLACEMENT:

Single Biological Parent Both Biological Parents Adoptive Parent Step Parent

Adult Relative (Specify Relation): _____

Adult Non-relative (Family Friend – Specify): _____

Foster Care Kinship Care Shelter (Specify): _____

Therapeutic Foster Care SHSP Home

Name of Child's Primary Caretaker(s): _____

Primary Language: English Spanish Other _____

Ethnicity: African – American Hispanic Asian – Pacific Caucasian/White
 Biracial: (Specify): _____

Telephone: (H) _____ **(W)** _____ **(Cell)** _____

Address: _____

CHILD'S LEGAL GUARDIAN: (If different than above)

Name(s) _____

Address: _____

Phone # _____

IF CHILD'S BIOLOGICAL PARENTS ARE NOT IDENTIFIED ABOVE, PLEASE COMPLETE THE FOLLOWING:

Biological Mother's Name: _____

Address: _____

Phone # _____

Ethnicity: African – American Hispanic Asian – Pacific Caucasian/White
 Biracial: (Specify): _____

Biological Father's Name: _____

Address: _____

Phone # _____

Ethnicity: African – American Hispanic Asian – Pacific Caucasian/White
 Biracial: (Specify): _____

Number of Biological Siblings: _____

Rights of biological parents terminated? YES (MOM) YES (DAD) YES (BOTH) NO

Please List ALL Persons Currently Living In the Placement:

1. _____ Age: _____ Relationship to Child: _____
2. _____ Age: _____ Relationship to Child: _____
3. _____ Age: _____ Relationship to Child: _____
4. _____ Age: _____ Relationship to Child: _____
5. _____ Age: _____ Relationship to Child: _____

CURRENT ABUSE ALLEGATIONS/REASON(S) FOR REMOVAL:

If there are no current abuse allegations, skip to page 4

If there are no current or past abuse allegations, skip to page 5

First Allegation:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sex Abuse - Caretaker | <input type="checkbox"/> Child on Child - Sexual | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Sex Abuse - Non-Caretaker (Adult) | <input type="checkbox"/> Child on Child - Physical | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sex Abuse - Unknown Perp | <input type="checkbox"/> Sexually Reactive Child | <input type="checkbox"/> Maltreatment-Other |
| <input type="checkbox"/> Physical Abuse - Caretaker | <input type="checkbox"/> Mental Illness - Caretaker | <input type="checkbox"/> Incarceration - Caretaker |
| <input type="checkbox"/> Physical Abuse - Non-Caretaker | <input type="checkbox"/> Poverty/Lack of Resources | <input type="checkbox"/> Substance Abuse - Caretaker |

Alleged Perpetrator: _____ **Age:** _____

Relation to Child: Biological Parent Step Parent Adult Relative Adult Non-relative
 Sibling Peer Other: _____

Is child currently having contact with the perpetrator? Yes No

IF yes, specify type of contact: Supervised Unsupervised Remains in home

DYFS Substantiated? Yes No Pending **Date:** _____

If No, reason: Pending Investigation Other (Please Specify: _____)

Legal Status:

Charged/arrested Investigation Sentenced Pending Dismissed Closed

IF MORE THAN ONE ALLEGATION CURRENTLY BEING INVESTIGATED COMPLETE SECOND ALLEGATION SECTION, OTHERWISE SKIP TO INVESTIGATION STATUS:

Second Allegation:

- | | | |
|--|---|--|
| <input type="checkbox"/> Sex Abuse - Caretaker | <input type="checkbox"/> Child on Child - Sexual | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Sex Abuse - Non-Caretaker (Adult) | <input type="checkbox"/> Child on Child - Physical | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sex Abuse - Unknown Perp | <input type="checkbox"/> Sexually Reactive Child | <input type="checkbox"/> Maltreatment-Other |
| <input type="checkbox"/> Physical Abuse - Caretaker | <input type="checkbox"/> Mental Illness - Caretaker | <input type="checkbox"/> Incarceration - Caretaker |
| <input type="checkbox"/> Physical Abuse - Non-Caretaker | <input type="checkbox"/> Poverty/Lack of Resources | <input type="checkbox"/> Substance Abuse - Caretaker |

Alleged Perpetrator: _____ **Age:** _____

Relation to Child: Biological Parent Step Parent Adult Relative Adult Non-relative
 Sibling Peer Other: _____

Is child currently having contact with the perpetrator? Yes No

IF yes, specify type of contact: Supervised Unsupervised Remains in home

DYFS Substantiated? Yes No Pending **Date:** _____

If No, reason: Pending Investigation Other (Please Specify: _____)

Legal Status:

Charged/arrested Investigation Sentenced Pending Dismissed Closed

INVESTIGATION STATUS OF CURRENT ALLEGATIONS:

Original allegation (as reported to DYFS): _____

What prompted the child's disclosure: _____

Child's specific statement/behavior (related to current allegation): _____

Date of most recent incident: _____ Date of First incident: _____

Date Received Report: _____

Number of incidents: One Multiple Unknown

Interview date(s): _____ Name of DYFS Interviewer: _____

Name of Prosecutor's Office/Police Interviewer: _____

Phone # _____

Other interviewer: _____

Location: Prosecution Investigator DYFS Physician Therapist
Were Sessions: Audiotaped Videotaped

Interviewer's Observations: _____

Statements of others regarding child's disclosure, etc. _____

PAST ABUSE ALLEGATIONS:

Has family had past involvement with DYFS: Yes No or Prosecutor's Office? Yes No

IF NO PREVIOUS DYFS INVOLVEMENT, SKIP TO BEHAVIORAL CHANGES SECTION:

IF YES, ANSWER NEXT SECTION: FIRST ALLEGATION:

PAST ABUSE ALLEGATIONS: (Continued)

FIRST ALLEGATION:

Allegation Type:

DYFS Substantiation:

Date:

Sex Abuse-Caretaker Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

Child on Child - Sexual Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

Neglect Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

Sex Abuse-Non-Caretaker (Adult) Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

Child on Child - Physical Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

Domestic Violence Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

Physical Abuse-Caretaker Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

Sexually Reactive Child Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

Maltreatment – Other Yes No Pending
Alleged Perpetrator: _____ Relation to Child: _____

BEHAVIORAL CHANGES (Please denote with a check if the child is exhibiting any behavioral problems):

Wetting Bed or Clothes Bed or Clothes Soiling Firesetting: Number of Incidents: _____
Dates: _____

Self Mutilation: When/Where: _____

If applicable, describe: _____

Substance Use: Date(s) _____ Substance: _____

Dangerous or Acting Out Behavior (Please Specify) _____

Suicidal Behavior Current Suicidal Thoughts: Yes No

Recent Attempt: Yes No If Yes, please explain: _____ Date: _____

Past Attempts: Yes No If Yes, please explain: _____ Date: _____

Other Behavior Problems (Please Explain): _____

Is child exhibiting sexualized behavior? No Yes **If yes, please answer the following:**

Touching self excessively Towards another child (# of incidents): _____
 Using an object Towards Animals

LEGAL ISSUES

Yes

No

Unknown

Please Explain (e.g., Custody Disputes, DYFS Litigation, Family Court, Civil Suit, Financial, Criminal, etc.):

MEDICAL and DEVELOPMENTAL HISTORY

Primary Healthcare Provider: _____ **Date last seen:** _____

Address: _____ **Phone Number:** () _____

Any Current Medical Problems: No Yes

If Yes, please explain: _____

Current and Past Medications (Medical & Psychiatric):

NAME	DOSE	PRESCRIBED BY	WHEN STARTED/ENDED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Developmental History: Unknown Normal Milestones

Delayed Milestones (Please explain): _____

Current School or Daycare: _____ **Grade:** _____

School Classification: Yes No Child Study Team Evaluation in Progress

Is the child currently refusing to attend school? Yes No

OTHER MENTAL HEALTH SERVICES RECEIVED:

Has the child ever required Psychiatric Hospitalization: No Yes Dates: _____

What Hospital: _____

If child is currently receiving any type of mental health services, please complete the following:

Individual Therapy Group Family School Counselor In-home

Name of current therapist/counselor : _____

Name of Agency: _____ Phone Number: _____

How long has child been receiving services: _____

Problem(s) Being Addressed: _____

COMPLETE THIS PAGE IF REFERRAL IS FOR A CHEC EVALUATION ONLY:

PRE-PLACEMENT PHYSICAL (attach copy):

Location: _____

Date: _____

CHILD'S BIOLOGICAL SIBLINGS:

NAME	GENDER	DOB	CURRENT LOCATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VISITATION? **NO** **SUPERVISED** **UNSUPERVISED** **UNKNOWN**

With Whom? _____

Frequency of Visitation? _____

SCHOOL INFORMATION:

Has child changed schools due to placement? **Unk** **No** **Yes**

Please explain: _____

Is child classified with disability or other problem? **Unk** **No** **Yes**

Please explain: _____

Has child been seen for IEP/CST? **Unk** **No** **Yes** Date of last eval: _____

Has child been suspended? **No** **Yes** *Please explain:* _____

Has child been truant? **No** **Yes** *Please explain:* _____

Has child had other disciplinary problems? **No** **Yes**

Please explain: _____