

**Northwest Connections
Crisis Services for Children Network Referral
County:**

Date:	Time Called:	Referral Time(1):	Coordination Time (2):
Documentation Time (3):	Total Time (1+2+3):		

CLIENT INFORMATION

Name:	DOB/Age:	Phone(s):	County of Residence:
Address:	City:	State:	Zip:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Location where evaluated:	Guardian Name and Contact information:
Social Worker Name: If consumer doesn't have a social worker, then who is the contact person at the county?	Social Worker Phone Number: If no worker, then County Contact Phone Number:	Authorization to bill obtained: <input type="checkbox"/> Yes <input type="checkbox"/> No Notification of Client Rights: <input type="checkbox"/> Yes <input type="checkbox"/> No Notification of Informed Consent: <input type="checkbox"/> Yes <input type="checkbox"/> No Notification of HIPAA: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Providers:	Current Medications:	Client is currently on: <input type="checkbox"/> Chapter 51 <input type="checkbox"/> TPC <input type="checkbox"/> Voluntary Other:	

Referral made by (include referent name, contact information, title):

Description of need for referral (Include pertinent AODA, MH, Medical information):

Aggression History (Indicate the level of aggression and settings in which aggression has occurred.):

Legal Issues (probation, upcoming court date(s), etc.):

Runaway History or Concerns:

History of sexual/physical abuse : Victim Victimizer

Additional information regarding sexual/physical abuse:

With the information obtained in the assessment would this child be appropriate to room with another child?

Yes No

Does the referring party have a request for a specific receiving agency? Yes No

If yes, name of facility:

Facility Questions:

Do you have other children in your home or program? Yes No

If so, would the addition of this child into the environment have any negative impact on the other child/children?

Yes No Explain:

Matched Facility (Include name of person at facility approving match, list all facilities contacted):

Transportation Plan (Include name of person transporting, transport company if applicable, cell phone, E.T.A):

NW Connections Staff Signature

Date