



The Children's Aid Home Programs
of Somerset County, Inc.
REFERRAL FORM

Date: _____ Name of Person Completing Referral _____

CHILD INFORMATION

Child Last Name	First	MI	D.O.B.	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address (Street Address, City, State, Zip Code)		County	Telephone Number(s)	SS Number	
		Race		Place of Birth	
Height:	Weight:	Hair Color:		Eye Color:	
Current School District / Address / Phone (if available)			Primary Language Spoken	Grade	

Reason for Referral (Be specific – Use additional sheets if necessary)

<input type="checkbox"/> School Problems	<input type="checkbox"/> Conduct Problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Other:
<input type="checkbox"/> Physical Aggression	<input type="checkbox"/> Runaway	<input type="checkbox"/> Family Problems	

Immediate Treatment Goals

Current Service Providers / Involved Parties (Use additional sheets if necessary.):

Name of Service Provider	Worker	Address (Street Address, City, State, Zip)	Dates of Placement	Type of Svc/Placement
1.				
2.				
3.				

Previous Placements and / or Services (Use additional sheets if necessary.)

Name of Service Provider	Address (Street Address, City, State, Zip Code)	Telephone	Provider Type
1.			
2.			
3.			

MEDICAL INFORMATION

Child's Primary Care Physician	Address (Street Address, City, State, Zip Code)	Telephone
Is the child on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Physical Health Care Concerns (e.g., allergies, physical problems, etc. Specify and attach information as appropriate)	
	Does child have any communicable diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current Medications (name of medication, dosage, time of dosage, and prescribing physician)		

INSURANCE INFORMATION**(PLEASE ATTACH A COPY OF THE CHILD'S INSURANCE**

Is child covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> MA/Access	<input type="checkbox"/> BC/BS	<input type="checkbox"/> UPMC	<input type="checkbox"/> Gateway	<input type="checkbox"/> Other (Specify)
Primary Physical Health Care Provider / Number(s):			Primary Behavioral Health Care Provider / Number(s):		
Secondary Physical Health Care Provider / Number(s):			Secondary Behavioral Health Care Provider / Number(s):		

PARENT INFORMATION

Biological Mother Last Name	First	Middle	Birth Date / /	Age
Address (Street Address, City, State, Zip Code)			Marital Status	Telephone
Biological Father Last Name	First	Middle	Birth Date / /	Age
Address (Street Address, City, State, Zip Code)			Marital Status	Telephone