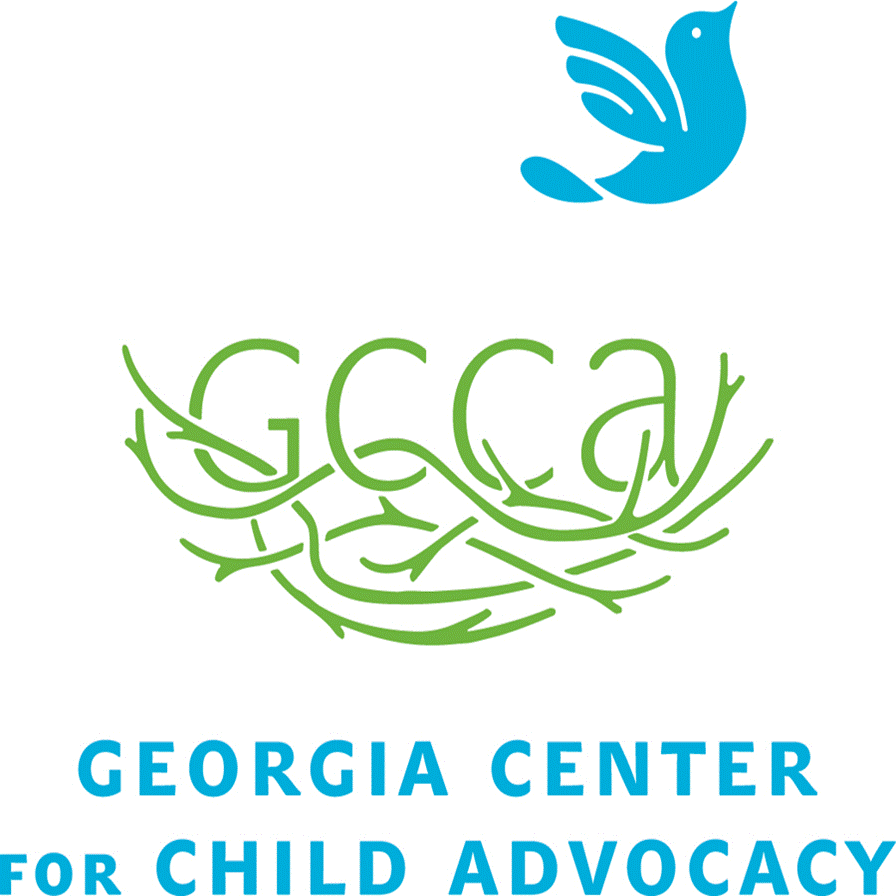
**Georgia Center for Child Advocacy**

***REFERRAL FORM***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral:** | |  | | |  | | | | |
| **Child’s Last Name:** | |  | | | **Child’s First Name:** | |  | | |
| **Child’s DOB:** |  | | **Ethnicity:** |  | | **Gender:** | Male  Female | **Age:** |  |

**Person Making the Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Is Referral Source caregiver?** NoYes **If no,** | | **Agency Name:** |  |
| **Caregiver notified of referral:** | Yes  No – ***Please notify caregiver immediately.*** | | |

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| **REASON FOR REFERRAL – Referral Source Report** |
|  |
| **What are the specific events that are leading to this referral?** |
|  |
| **What are the child’s symptoms of concern (e.g., anxiety, depression, behavior problems)?** |
|  |
| **Other important information about this child (e.g. family dynamics related to child’s symptoms of concern):** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CAREGIVER INFORMATION** | | | | | | | | | | | | |
| **Primary caregiver’s name(s):** | | |  | | | | | | | | | |
| **Relationship to child:** | | |  | | | | | | | | | |
| **Address:** |  | | | | | | | | | | | |
| **Home phone:** | |  | | | **Cell phone:** | |  | | **Work phone:** | |  | |
| **Alternate phone:** | |  | | | **Good time to call:** | | | AM PM EVE | | Other: | |  |
| **Legal Guardian:** | | Caregiver | | DFCS | | Other: | |  | | | | |

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| **BIOLOGICAL PARENT INFORMATION – If different from caregiver above** | | | | | | | | | | |
| **Parent’s name:** | | |  | | | | | | | |
| **Relationship to child:** | | |  | | | | | | | |
| **Address:** |  | | | | | | | | | |
| **Home phone:** | |  | | **Cell phone:** |  | | **Work phone:** | |  | |
| **Alternate phone:** | |  | | **Good time to call:** | | AM PM EVE | | Other: | |  |
|  | | | | | | | | | | |
| **BIOLOGICAL PARENT INFORMATION – If different from caregiver above** | | | | | | | | | | |
| **Parent’s name:** | | |  | | | | | | | |
| **Relationship to child:** | | |  | | | | | | | |
| **Address:** |  | | | | | | | | | |
| **Home phone:** | |  | | **Cell phone:** |  | | **Work phone:** | |  | |
| **Alternate phone:** | |  | | **Good time to call:** | | AM PM EVE | | Other: | |  |

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| **DFCS/LE/JUV CT INFORMATION** | | | | | | | | | | | | | | | |
| **DFCS involvement:** | | | No  Yes (In the past)  Yes (Currently) | | | | | | | | | | | |
| **If yes, caseworker name:** | | | |  | | | | | | **Primary County:** | | | |  | |
| **Caseworker phone:** | |  | | | | | **Cell phone:** | |  | | | | **Fax:** |  | |
| **Caseworker email:** | |  | | | | | | | | | | | | | |
| **Is child in therapeutic foster care?** | | | | | | No  Yes – **Agency:** | | | |  | | | | | |
| **Is biological mother’s parental rights terminated?** | | | | | | | | Yes  No  Do not know  N/A | | | | | | | |
| **Is biological father’s parental rights terminated?** | | | | | | | | Yes  No  Do not know  N/A | | | | | | | |
| **Is there a plan for reunification with parents?** | | | | | | | | Yes  No  Do not know  N/A | | | | | | | |
| **Is there a permanency plan for the child** | | | | | | | | Yes  No  Do not know  N/A | | | | | | | |
| **Is Law Enforcement involved?** | | | | | | No  Yes – **Contact Person:** | | | | | |  | | | |
| **Contact phone:** | |  | | | | | **Cell phone:** | |  | | | | **Fax:** |  | |
| **Is Juvenile Court/DJJ involved?** | | | | | No  Yes – **Contact Person:** | | | | | |  | | | | |
| **Contact phone:** | |  | | | | | **Cell phone:** | |  | | | | **Fax:** |  | |
| **If necessary, then please use the space below to elaborate on the permanency plan:** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | |  | | | | | **OTHER PROFESSIONALS** | | | | | **Therapist:** |  | **Phone:** |  | | **Psychiatrist:** |  | **Phone:** |  | | **School Counselor:** |  | **Phone:** |  | | **Other:** |  | **Phone:** |  | | | | | | | | | | | | | | | |

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| **OFFICE USE ONLY** |
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**Email completed forms to** [**maggieh@gacfca.org**](mailto:maggieh@gacfca.org) **and they will be reviewed by our Intake Team. The parent/legal guardian will be contacted for additional information and to schedule an intake assessment for the child. Questions – Contact Maggie Huddle, LCSW (770) 830-4012.**