**Georgia Center for Child Advocacy**

***REFERRAL FORM***

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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| **REASON FOR REFERRAL – Referral Source Report** |
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| **What are the specific events that are leading to this referral?** |
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| **What are the child’s symptoms of concern (e.g., anxiety, depression, behavior problems)?**  |
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| **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:** |
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| **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** **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.**