For Children's Sake of Virginia **Intake Referral Sheet/Admissions**

Name of Referrer: _____ Agency/County: _____

Agency Address: _____

Type of Contact: ☐ Phone ☐ Email ☐ Triage ☐ On Call/After Hours ☐ Other: _____

Date: _____ Phone #: _____ Fax #: _____

Child Name: _____ DOB: _____/_____/_____ Age: _____ M ☐ F ☐

Child Name: _____ DOB: _____/_____/_____ Age: _____ M ☐ F ☐

Child Name: _____ DOB: _____/_____/_____ Age: _____ M ☐ F ☐

Child Name: _____ DOB: _____/_____/_____ Age: _____ M ☐ F ☐

Race: _____ Religion: _____

Language(s): _____ Need Interpreter? YES ☐ NO ☐

Permanency Goal & Date Anticipated: _____

Legal Guardian & Emergency Contacts

Name: _____

Address: _____

Phone:_____**Fax:**_____

Date placement needed: _____

Type of Family Needed:

☐ AA ☐ Hispanic ☐ Caucasian ☐ N/A

☐ Single Mom ☐ Single Dad ☐ 2 Parent ☐Pets ok

☐ Younger children ☐ Older children ☐ No other children

Family Preferences:

_____

_____

_____

Services needed from FCSVA:

☐ TFC ☐ Adoption ☐ Respite ☐ Counseling ☐ Supervised Visitation ☐ Other

_____

Reason for Referral:

_____

_____

_____

Placement History:

_____

_____

_____

Behaviors in the home or previous living situation:

_____

_____

_____

_____

Updated 7/07; 2/1/11; 6/15/12; 4/3/14

Legal Concerns (if any):

_____

_____

Strengths, Skills, Interests & Talents:

_____

_____

_____

School

Current School Location:_____

Current Grade:_____**IEP:** YES☐ NO☐ _____

Can the child change schools? YES☐ NO☐ N/A☐

Has a Best Interest Determination Meeting been scheduled? YES☐ NO☐ **If yes**, list date, location and participants:

_____

If no meeting has been scheduled, what is the transportation plan for school?_____

_____

Adjustment to School:_____

_____

Day Care or Nursery and Adjustment:_____

_____

_____

Emotional & Psychological

Are there any emotional or psychological needs, issues or problems? YES☐ NO☐ N/A☐ If yes, please explain:

_____

_____

Is the client receiving therapy? YES☐ NO☐ If yes, please explain:

Name of therapist: _____

Location: _____

How often, and for how long? _____

Can the child change therapists? YES☐ NO☐ N/A☐

Medical

Diagnosis?

_____

_____

_____

_____

_____

_____

All Medications (Rx and non-Rx) Frequency and Doseage Include Reason for Medication:

_____

_____

_____

_____

_____

_____

Medical/Health Issues/History (for children under 1 yr, see regs pg. 57):

_____

_____

_____

Abuse History

History of sexual abuse YES ☐ NO☐ UNKNOWN☐ If yes, by whom:_____

History of sexual acting out YES ☐ NO☐ UNKNOWN☐ _____

History of physical abuse YES ☐ NO☐ UNKNOWN☐ If yes, by whom:_____

History of physical aggression YES ☐ NO☐ UNKNOWN☐ _____

History of verbal aggression YES ☐ NO☐ UNKNOWN☐ _____

History of neglect YES ☐ NO☐ UNKNOWN☐ If yes, by whom:_____

Birth Family

Birth/Adoptive Mother Strengths and Needs _____

_____

Birth/Adoptive Father Strengths and Needs _____

_____

Current Foster Home Strengths and Needs _____

_____

Visitation

Will there be family or sibling visitation? YES ☐ NO☐ UNKNOWN☐ If yes:

Names of those who will be present:_____

Location of visitation:_____

Days and times of visitation_____

Who will provide transportation to visitation?_____

_____

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Staffing Attendees: **Date of Staffing:**

_____ _____ _____

_____ _____ **Placement or Deferral Date:**

_____

Meets Criteria: ☐ YES ☐ NO **Placed:** ☐ YES ☐ NO

Families considered & dates contacted:

_____

_____

_____

_____

Pre-Placement Visits (who/when):

_____

_____

_____

Agency Interview scheduled for (not required for placements in under 72 hours):

_____

_____

_____

Has an icebreaker meeting been set up? If so, date & time of meeting:

_____

_____

_____

Reasons placed:

_____

_____

Reasons not placed:

_____

_____

FCSVA Signature/Title:

_____

Updated 7/07; 2/1/11; 6/15/12; 4/3/14