TENNESSEE VOICES FOR CHILDREN
500 Professional Park Dr.
Goodlettsville, TN 37072
PHONE: 615-269-7751
FAX: 615-269-8914

Family Connection
REFERRAL FORM

Please fill form out completely

DATE:______________

☐ Prevention ☐ Placement Stabilization

☐ Reunification ☐ Resource Parent Support (Step-down)

Child/Youth information

Child's Full Legal Name:
____

SS#: ___________________ Male: _____ Female: _____ Race:_____________

DOB: ___________________ Age: ___________ Height/Weight: ______________

Parent/Caregiver information

Mother's Name: ____
Address: ____
City, zip code: ____
Home/Cell/Work Phones: ____

Father's Name: ____
Address: ____
City, zip code: ____
Home/Cell/Work Phones: ____

Other Caregiver Name: ____
Address: ____
City, zip code: ____
Home/Cell/Work Phones: ____

Does this child have any family members in state custody?
Members' name and placement:

____
____
____

School information
Last School Attended: ____

Developmentally Disabled: ☐ Yes ☐ No

Special Education Needs: ☐ Yes ☐ No

____
____

Current school and grade: _________________________________

Juvenile Court Involvement
Delinquent History/Juvenile Court Involvement
(explain any adjudicated charges):

____
____
____

On probation ☐ Yes ☐ No
Probation officer name and contact info, terms of probation:

____
____

Mental Health/Behavioral information/Physical Health

Previous Psychiatric History (explain and provide dates):___________________

____
____
____

Suicidal/Homicidal ideations or gestures within the last six months:
☐ Yes ☐ No If yes, explain:___________________________________

____
____
____

FSIQ: _______ Performance:_______ Verbal:________ Date of Testing:_______

Adaptive level of functioning: ____________________ Date of Testing:_______

DSM Diagnosis ____

____

Consistent Behaviors of Concern (be specific and include who reported the behavior):____

____

____

____

Positive Behaviors/Interests/Strengths: ______________________________

____

____

Chronic Health Conditions/Special Medical Needs and/or Handicapping Conditions:____

____

____

Taking Psychotropic Medications: ☐ Yes ☐ No
Medications (Names/Dosages):______________________________

____

____

____

Has child been accused of sexual perpetration and/or acting out: ☐ Yes ☐ No
If yes, please explain:______________________________

____

____

Is there a history of abuse: ☐ Yes ☐ No
If yes, please indicate by whom and explain:______________________________

____

____

____

Has this child received abuse related treatment: ☐ Yes ☐ No
If yes, specify dates and providers______________________________

____

____

____

Is there anyone that this child cannot have contact with: ☐ Yes ☐ No
If yes, please identify them:

____

____

Referral Source Information

Department________________________ Referral person:____________________
Phone: _______ Ext.: ____
E-mail address: _____________________________ Fax: (___)______________

Supervisor:_________________________________ Phone:_________ Ext. ____
E-mail address: ____
____
****

If this is a DCS referral for services:

If not in custody:
Reason for DCS involvement:
____
____
____

If in custody:
Date of Custody: ________________________
County: ____________________

Adjudication: ☐ Dependent/Neglect ☐ Unruly ☐ Delinquent

Custody Division: ☐ Social Services ☐ Juvenile Justice ☐ Non-Custody

Have parental rights been terminated: ☐ Yes ☐ No

Has CFTM occurred: Yes ☐ No ☐
If not, when is one scheduled ________
Has Disruption Staffing occurred Yes ☐ No ☐
Has Permanency Review occurred Yes ☐ No ☐

With whom is child presently placed? ____________________________________

Is placement scheduled to change: Yes ☐ No ☐ If so, when is placement planned?
____

Explain reason for custody:____
____

Placement Level: ☐ Level I Services
☐ Level II Services
☐ Level III Services

Type of Placement: (Please check)
Foster Placement: _________ Safety Placement: ______
Relative Placement: ________ Parent/Biological: ______

DCS Placement history (if applicable):
____
____
____

Send completed forms to:

Paul Highfill Program Manger
Family Connection Program
Tennessee Voices for Children
Fax: 615-269-8914
E-mail: phighfill@tnvoices.org