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| **SECTION I: Identifying Information** |
| **Child’s Name:** |       | **Child’s DOB** |      | [ ]  **Male****[ ]  Female** |
| Client ID: |       | Date Referred:  |       | Time Referred: |       | [ ]  AM [ ]  PM |
| FACTS Case Number:  |       | Permanency Goal: |       |
| CINC Court Case Number:  |       | Judicial District:  |       |
| Parent/Caregiver Name:  |        | Parent/Caregiver Name: |       |
| Address: |       | Address:  |       |
| Phone: |       | Phone:  |       |
| **SECTION II: Agency Contact Information** |
| Referring CWCMP Case manager:  |       | Phone: |       |
| Address: |       | Email: |       |
| DCF Foster Care Liaison: |       | Phone: |       |
| Address: |       | Email: |       |

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| **SECTION III: Child’s Placement Information** |
| Date of QRTP Placement:  |       |  |
| Name of Child’s Current Placement:  |       | Email Address:       |
| Address:  |       | Phone Number:       |
| **SECTION IV: Other Individuals able to provide information on child’s functioning (IE: Foster Parents, School Personnel, Therapists, etc.)** |
| Name | Relationship to Child | Contact Information |
|       |       |       |
|       |       |       |
|       |       |       |
| **SECTION V: Rationale for requesting an assessment for QRTP placement (Presenting problem and/or description of child’s behaviors)** |
|       |
| **Attach all completed assessments to assist with the functional assessment of the child. These assessments may include, but are not limited, to the following:**  |
| [ ]  Structured Decision Making (SDM)[ ]  Child Stress Disorder checklist-KS (CSDC-KS)[ ]  Child Report of Post-Traumatic Symptoms (CROPS)[ ]  Parenting Stress Index – Short Form (PSI-SF)[ ]  Individual Education Plan (IEP) | [ ]  Child and Adolescent Functional Assessment Scale (CAFAS)[ ]  North Carolina Family Assessment Scale (NCFAS) |
| Once this form is complete please email to: QRTP@healthsrc.orgCall HealthSource Integrated Solutions Program administration support to discuss referral: 785-291-9138 |

