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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 | |
|  | |  | |  | |
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| **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.org](mailto:QRTP@healthsrc.org)  Call HealthSource Integrated Solutions Program administration support to discuss referral: 785-291-9138 | | | | | |

