**Foster Care Referral**

Child’s Name: ­­­­­Click or tap here to enter text. Child’s Date of Birth: ­­­­­Click or tap here to enter text.

Level of Care:  Family Foster  Therapeutic Foster

Gender: Male  Female  Transgender  Non-binary  Other

Race/Ethnicity:  American Indian  Alaska Native  First Nations

Black/African American  Hispanic/LatinX  Middle Eastern

Native Hawaiian  Pacific Islander  White

Unknown  Not Listed

Why the youth in care: Click or tap here to enter text.

Visitation Schedule: Click or tap here to enter text.

Grade/School/Daycare: Click or tap here to enter text.

Appointments/Therapist: Click or tap here to enter text.

Medications: Click or tap here to enter text.

Characteristics, Medical Conditions, and Behaviors:

Academic Delays  Yes  No  Unknown

ADD/ADHD  Yes  No  Unknown

Alcohol/Drug Use  Yes  No  Unknown

Asthma  Yes  No  Unknown

Autism Spectrum Disorder  Yes  No  Unknown

Bedwetting or wets/soils themselves  Yes  No  Unknown

Conduct Disorder  Yes  No  Unknown

Commercial Sexual Exploitation of Children  Yes  No  Unknown

Depression  Yes  No  Unknown

Disruptive in School/Daycare  Yes  No  Unknown

Experienced Physical Abuse  Yes  No  Unknown

Experienced Sexual Abuse  Yes  No  Unknown

History of Assault or Physical Aggression  Yes  No  Unknown

History of Cruelty to Animals  Yes  No  Unknown

Developmentally Inappropriate Sexual Behavior  Yes  No  Unknown

History of Manipulation or Excessive Lying  Yes  No  Unknown

History of Smearing Feces  Yes  No  Unknown

History of Running Away  Yes  No  Unknown

History of Behavior Problems in School  Yes  No  Unknown

History of Setting Fires  Yes  No  Unknown

History of Stealing  Yes  No  Unknown

Intellectually Challenged  Yes  No  Unknown

Juvenile Justice or Probation  Yes  No  Unknown

Learning Disability  Yes  No  Unknown

LGBTQ+  Yes  No  Unknown

Medically Fragile  Yes  No  Unknown

Potty Trained  Yes  No  Unknown

Oppositional Defiant Disorder  Yes  No  Unknown

Physically Disabled  Yes  No  Unknown

Prenatal Alcohol/Drug Exposure  Yes  No  Unknown

Requesting FP Transportation to Visitation  Yes  No

Schizophrenia  Yes  No  Unknown

Self-Harm  Yes  No  Unknown

Please explain any “Yes” answers: Click or tap here to enter text.

Anything else you would like us to know? Click or tap here to enter text.

Social Workers Name: ­­­­­Click or tap here to enter text. Cell Phone Number: ­­­­­Click or tap here to enter text. Office Phone Number: ­­­­­Click or tap here to enter text. Email Address: ­­­­­Click or tap here to enter text.

Please return this form along with all supporting documentation, such as the most current CCA, to [admissions@thompsoncff.org](file:///C:\Users\lhaydon\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\2YHHOT24\admissions@thompsoncff.org).