Radiance Innovative Services

Referral Form

Referring Agency: DCF

Date of Referral:___________________________________ Type of Referral:___________________________________

Referring Worker:__________________________________

Phone:____ Email:____

Supervisor Name:__________________________________

Phone:____ Email:____

Client Information: Case Name:____ Case Link #:___________________

Parents:

(1) Name: ____________________________ Relationship to Child: ______________ DOB: _________ Age:_____

Address: Street: ___________________________ City: __________________________ State: _____ Zip: ______

Phone:____________________________________ Alternative Phone:_________________________________

(2) Name: ____________________________ Relationship to Child: ______________ DOB: _________ Age:_____

Address: Street: ___________________________ City: __________________________ State: _____ Zip: ______

Phone:____________________________________ Alternative Phone:_________________________________

Caretakers (children placed outside of home):

(1) Name: ____________________________ Relationship to Child: ______________ Date of Placement: _________

Address: Street: ___________________________ City: __________________________ State: _____ Zip: ______

Phone:____________________________________ Alternative Phone:_________________________________

(2) Name: ____________________________ Relationship to Child: ______________ Date of Placement: _________

Address: Street: ___________________________ City: __________________________ State: _____ Zip: ______

Phone:____________________________________ Alternative Phone:_________________________________

Child(ren):

(1) Name:_________________________________ DOB: ____________ SSN (SIS if DSS): _______________________

Ethnicity:_______________ Language:__________________ Gender:________ Child Link#____________________

School:________________________________ Grade:________ City:_________________ Phone:________________

Day Care Provider:____

Address: Street: ___________________________ City: __________________________ State: _____ Zip: ______

Phone:____________________________________ Date of Removal:_________________________________

(2) Name:_________________________________ DOB: ____________ SSN (SIS if DSS): _______________________

Ethnicity:_______________ Language:__________________ Gender:________ Child Link#____________________

School:________________________________ Grade:________ City:_________________ Phone:________________

Day Care Provider:____

Address: Street: ___________________________ City: __________________________ State: _____ Zip: ______

Phone:____________________________________ Date of Removal:_________________________________

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(3) Name:________________________________ DOB: ____________ SSN (SIS if DSS): _______________________
Ethnicity:_______________ Language:_________________ Gender:________ Child Link#___________________
School:_______________________________ Grade:________ City:________________ Phone:_______________
Day Care Provider:____
Address: Street: __________________________ City: _________________________ State: _____ Zip: ______
Phone:___________________________________ Date of Removal:________________________________

(4) Name:________________________________ DOB: ____________ SSN (SIS if DSS): _______________________
Ethnicity:_______________ Language:_________________ Gender:________ Child Link#___________________
School:_______________________________ Grade:________ City:________________ Phone:_______________
Day Care Provider:____
Address: Street: __________________________ City: _________________________ State: _____ Zip: ______
Phone:___________________________________ Date of Removal:________________________________

Legal Status of Case:____(committed; TPR, protective supervision)

Risk Assessment:

☐ Abuse ☐ Neglect ☐ Medically Fragile ☐ Educational ☐ Other (please explain)

Other explanation: ____

Brief History of DCF Involvement:

History of mental health, Substance Abuse, Domestic Violence or criminal Involvement:
(provide information for parents and children)

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Other Agencies or Services Past or Currently Involved with the Family:
(include contact name and number)

Reason for Referral:

Radiance Innovative Services

Referral Form

Outcomes of Service: (goals client is to accomplish during services)

(1)

(2)

(3)

(4)

(5)

For RIS Use Only

Approved Number of hours per week:	
Approved Dates:	
Approved Visitors:	
Approved Locations:	