

**Family & Children's Service  
Connecting Kids Referral Face Sheet**

E-mail form to [connectingkids@fcsnashville.org](mailto:connectingkids@fcsnashville.org) or fax to Schlitta Patton at 615-321-4157

<b>CHILD'S Name (Last, First):</b>			<b>Phone Numbers</b>		<b>Client ID#:</b>
			<b>Home:</b>		
<b>Current Placement Address:</b>			<b>Apt.</b>	<b>RP Work:</b>	<b>Referral Date:</b>
			<b>RP Cell:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>SSN:</b>		
			<b>DOB:</b>	<b>Date child came into custody:</b>	
<b>County:</b>			<b>Gender:</b> -Select from list-	<b>Ethnicity:</b> -Select from list-	
<b>LEVEL OF CARE:</b>	-Select from List-		Notes:		
<b>Resource Parents: (Last, First):</b>			<b>Type of Placement:</b>		
			<input type="checkbox"/> Foster Placement <input type="checkbox"/> Trial Home Visit (Start date):		
			<input type="checkbox"/> Kinship Placement		
			<input type="checkbox"/> Foster Adopt		
			<input type="checkbox"/> Pre-Adoptive		
			Does the referred child have other siblings already in custody? Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Current Permanency Goal:</b>					
<input type="checkbox"/> Reunification					
<input type="checkbox"/> Adoption					
<input type="checkbox"/> Permanent Guardianship			Guardianship Date:		
<input type="checkbox"/> Independent Living					
<b>Services Requested:</b>	<input type="checkbox"/> Intensive Attachment Services <input type="checkbox"/> Family & Individual Counseling <input type="checkbox"/> Assessment <input type="checkbox"/> Court Testimony <input type="checkbox"/> Family Intervention <input type="checkbox"/> Coaching & Permanency Teaming <input type="checkbox"/> Support Implementation of SAFE <input type="checkbox"/> Support Group for Resource Families & Children <input type="checkbox"/> Crisis Intervention & Stabilization <input type="checkbox"/> Collaborative Enrichment <input type="checkbox"/> Exit Interview				
<b>Reason for Referral (Presenting Issues) :</b>					
<b>Provider Agency Worker Information</b>					
<b>Agency Name:</b>					
<b>Worker Name:</b>		<b>Office Phone:</b>		<b>Fax Number:</b>	
<b>Address:</b>		<b>E-Mail Address:</b>			
<b>DCS/Family Service Worker Information</b>					
<b>Name:</b>					
<b>County of Venue:</b>					
<b>Office Phone:</b>		<b>Fax Number:</b>		<b>E-Mail Address:</b>	
<b>Address:</b>					
<b>Signature and Title</b>					
<b>DCS Case Manager:</b>		<b>Date:</b>		<b>Psychologist/MSW:</b>	
				<b>Date:</b>	
<b>DCS Team Leader:</b>		<b>Date:</b>		<b>Referring Person:</b>	
				<b>Date:</b>	