LRCS FAMILY RESOURCE CENTER

Engage. Empower. Inspire.

Family Centered Early Supports and Services Referral Form

Child's Name: _____ **Gender:** M F **DOB:** _____

Referral Date: _____ **Reason for Referral** (*diagnosis code if applicable*): _____

_____

Physical Address: _____ **Foster Care: (***if yes, complete back of form***)**: Y N

Parent/Guardian (1): _____ **Relationship**: _____

Phone #: _____ **Email**: _____

Physical Address: _____

Mailing Address: _____

Parent/Guardian (2): _____ **Relationship**: _____

Phone #: _____ **Email**: _____

Physical Address: _____

Mailing Address: _____

Referral Source Name: _____ **Phone #:** _____

Referral Agency: _____

Address: _____ **Are parents aware of referral:** Y N

Primary Care Physician: _____ **Phone #:** _____ **Fax:** _____

Address: _____

Type of Insurance: _____

Primary Language: _____ **Family needs an interpreter**: Y N

Race *(circle all applicable)***:** White *(not Hispanic)* Indian/Native American Asian/Pacific Islander

Black/African American *(not Hispanic)* Multi-Racial Latino-Hispanic

Status: US Citizen Refugee Immigrant Work Visa Unspecified

Living arrangements: Lives with family Homeless DYCF Foster home Other: _____

Name of person completing form: _____ **Date**: _____

Signature: _____

(LRCS- FRC Internal Agency Use Only)

Date referral received: _____ **DUCK #:** _____

Intake Date: _____ **Eval & IFSP Date**: _____ **45 Days**: _____

Diagnosis Code/ name: _____ **Intake Diagnosis:** _____

Family Resource Center 719 N. Main St. P O Box 509, Laconia, N.H. 03247
www.lrcs.org Phone: (603) 524-8811 Fax (603) 524-0702

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For children placed in Foster Care

Is this foster care placement confidential?: Y N

Foster Parent (1): _____ **Relationship**: _____

Phone #: _____ **Email**: _____

Physical Address: _____

Mailing Address: _____

Foster Parent (2): _____ **Relationship**: _____

Phone #: _____ **Email**: _____

Physical Address: _____

Mailing Address: _____

NOTES REGARDING DCYF / FOSTER PLACEMENT: _____

_____

_____

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