



Referral / Placement Form - send to NKDreferral@nexuskindred.org

Program: Foster Care Short Term Foster Care Whole Family Adoption

Date of Referral:

Taken by:

Name:

DOB:

Age:

Gender:

Race:

- American Indian/Alaskan Native
- Asian
- Black or African American
- Native Hawaiian/Pacific Islander

- White
- Two or More Races
- Unknown
- Other:

Ethnicity: Hispanic Not Hispanic Unknown

Tribal Affiliation:

Registered: Yes No Unknown

SW / PO:

County:

Phone:

Email:

Custody:

Strengths: *(extra curricular, home, personal, school)*

Interests:

Geographic Preference:

If preferred geography cannot be met, can referral be made:

- Statewide Central Metro Northeast Northwest Southern

Foster Family Composition:

No Younger Children

Required Does Not Matter

2-Parent Home

Required Does Not Matter

At-Home Parent

Required Does Not Matter

Placement Authorization: *(Need Document)* CHIPS Delinquency TPR Voluntary

Reason for Out-of-Home Placement/Presenting Factors:

Current Residence:

Previous Placements:

Family Circumstances:

DSM Diagnosis:

- | | | |
|--|---|-------------------------------|
| <input type="checkbox"/> ADD | <input type="checkbox"/> Bi-Polar | <input type="checkbox"/> ODD |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Conduct Disorder | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> RAD |
| <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> Other: | |

History of Abuse: None Physical Sexual Emotional Psychological
By Whom: **Client's Age at Time of Abuse:**

History of Chemical Abuse or Treatment:

History of Physical or Sexual Aggression:

- Victim Perpetrator

History of Self Abusive Behavior:

Behavior Concerns:

- | | | |
|--|--|---|
| <input type="checkbox"/> Animal Cruelty | <input type="checkbox"/> Encopresis | <input type="checkbox"/> Sexually Active |
| <input type="checkbox"/> Depressed/Withdrawn | <input type="checkbox"/> Enuresis | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> DD | <input type="checkbox"/> Impulsive/Explosive | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Dishonesty | <input type="checkbox"/> Running | <input type="checkbox"/> Toileting Issues |
| <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Self-Harm | |

Supervision Requirements:

- Eyes-on Developmentally Age Appropriate Other:

Medical Concerns:

Allergies:

Medication(s) & Purpose(s):

Current Therapy Plan:

Anticipated Therapy Plan:

Current or Last School:

Grade:

School Location:

IQ:

Special Education Program:

Behavior/Ability:

Anticipated Length of Placement:

Family Involvement/Visitation:

Placement Needed By:

Permanency Plan: Adoption Kinship Care Long-Term Foster Care Reunification

Other Useful Information