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***Parenting for the Future – Referral Form***

Sharon Carson

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**4D Line**

**FAX**

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| **PROGRAM:**  **PARENTING FOR THE FUTURE**  **1501 Xerxes Avenue North**  **Minneapolis, MN 55411**  **Phone: 763-521-3477**  **Fax: 763-521-3893** | **DATE OF REFERRAL:**  **REFERRAL SOURCE Name and Agency:** | | **REFERRAL CONTACT INFORMATION:**  **Phone:**  **Fax:**  **Email:** | |
|  | | | | |
| **PARENT(S)** | | | | |
| First Name | | Last Name | Date of Birth | |
| Current Address Rent Own | | | City/State/Zip | |
| Social Security Number | | Race/Ethnicity/Tribe | Relationship to child | |
| Cell Phone: | | Home Phone | Work/School Phone | |
| Estimated IQ  ☐Above 80 ☐ 70-79 ☐ 60-69 ☐ Below 60 | | Estimated Adaptive Functioning Level  ☐Adult Level (over age 19)  ☐ Young adult level (17-19 years)  ☐ Adolescent level (12-16 years)  ☐ Pre-adolescent level (8-12 years) | | |
| **Adults living in household besides primary client** | | | | |
| ☐ Spouse/Partner Name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Total number of children in household\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐Other relatives(number)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐Other non-relatives(number)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Children with special needs- List a number for each group** | | | | |
| \_\_\_\_\_\_Medically Fragile \_\_\_\_\_\_Behavior Problems \_\_\_\_\_\_DD/FAS \_\_\_\_\_\_Mental Health Issues/SED \_\_\_\_\_ADHD  \_\_\_\_Other Learning Disability ------ No Special Needs | | | | |
| **CHILD** | | | | |
| First Name | | Last Name | Date of Birth | |
| Special Needs | | Race/Ethnicity/Tribe | Relationship to Child | |
| **CHILD** | | | | |
| First Name | | Last Name | Date of Birth | |
| Special Needs | | Race/Ethnicity/Tribe | Relationship to Child | |
| **OTHER AGENCIES INVOLVED WITH FAMLY**  **NAME ORGANIZATION NAME CONTACT NUMBER** | | | | |
|  | | | | |
|  | |  |  | |
|  | |  |  | |
| **MFIP Case Number (if applicable)** | | | | |
| **MEDICAL** | | | | |
| Health Care Provider/ Clinic | | Address | | Contact Number |
| Dental Care Provider/Clinic | | Address | | Contact Number |
| Diagnosis | | | | |
| Medications | | | | |
| **Psychotropic Medications** | | | | |
| ☐No psychotropic medications currently prescribed.  ☐Currently taking psychotropic medications as directed.  ☐Has been prescribed psychotropic medications but is not taking as directed or not taking at all. | | | | |
| **Medical/Mental Health issues we should know about? (check all that apply)** | | | | |
| ☐Chemical Dependency ☐ Mental Illness ☐Trauma History ☐ Brain Injury ☐ Disease(brain disease, physical impairment due to disease, etc.) ☐ Hearing Impairment ☐ Visual Impairment ☐ Processing Delay ☐ History of Depression ☐ ADHD ☐ Other learning disability | | | | |

**Other Information You Would Like Family Partnership To Know:**