****

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

Sharon Carson

***scarson@thefamilypartnership.org***

Office (612) 977-3223 | ***Fax:*** (763) 521-3893

**4D Line**

**FAX**

|  |  |  |
| --- | --- | --- |
| **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:**