Rowan Medicine
CARES INSTITUTE
CARES Institute

CHEC Program
Phone: 856-566-6799 Fax: 856-566-6838

# REFERRAL FORM

revised 04/17/17

Date of Referral: Spirit Case ID # Spirit Person ID #

**INITIAL OUT-OF-HOME PLACEMENT DATE**:

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**TYPE OF EXAM:** ☐ CHEC Evaluation ☐ Medical CHEC

**PREFFERED LOCATION FOR VISIT:** ☐ 42 East Laurel Road, Suite 1100, **Stratford**, NJ 08084
☐ 1051 W. Sherman Avenue, Bldg. 5 Unit A, **Vineland**, NJ 08360

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**PATIENT INFORMATION:**

**Child's Name:** **Age:** **DOB:**

**Gender:** ☐ Female ☐ Male **Language(s):** ☐ English ☐ Spanish ☐ Other (Specify):

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Race:** ☐ African -American ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian/White
☐ Native Hawaiian/Other Pacific Islander ☐ Biracial (Specify): ☐ Other (Specify):

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**REFERRAL INFORMATION:**

**DCP&P Caseworker:** **Phone #:** **Cell:** **Fax:**

**Supervisor:** **Phone #:** **Cell:** **Fax:**

**Child Health Unit Nurse:** **Phone #:**

**DCP&P Office in which referral originated:**

☐ DCP&P Camden North ☐ DCP&P Camden East ☐ DCP&P Gloucester West ☐ DCP&P Burlington East
☐ DCP&P Camden Central ☐ DCP&P Camden South ☐ DCP&P Gloucester East ☐ DCP&P Burlington West
☐ DCP&P Cumberland West ☐ DCP&P Cumberland East ☐ DCP&P Atlantic East ☐ DCP&P Atlantic West
☐ DCP&P Cape May ☐ DCP&P Salem ☐ Other (Specify):

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**BILLING INFORMATION:**

Medicaid Number: Effective Date:

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**CHILD'S CURRENT PLACEMENT:**

☐ Adult Relative (Relation): ☐ Adult Non-relative (Family Friend Specify):

☐ Foster Care ☐ Residential Treatment Facility (Specify): ☐ Shelter (Specify):

**Name of Child's Primary Caregiver(s):**

**Primary Language:** ☐ English ☐ Spanish ☐ Other (Specify):

**Telephone: (H)** **(W)** **(Cell)**

**Address:**

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**BIOLOGICAL FAMILY INFORMATION:**

**Biological Mother's Name:** **Biological Father's Name:**

**CURRENT ABUSE ALLEGATIONS/REASON(S) FOR REMOVAL: (please check all that apply)**

| | | |
|---|---|---|
| ☐ **Sex Abuse - Caretaker** | ☐ **Child on Child - Sexual** | ☐ **Neglect** |
| ☐ **Sex Abuse - Non-Caretaker (Adult)** | ☐ **Child on Child - Physical** | ☐ **Domestic Violence** |
| ☐ **Sex Abuse - Unknown Perp** | ☐ **Sexually Reactive Child** | ☐ **Maltreatment - Other** |
| ☐ **Physical Abuse - Caretaker** | ☐ **Mental Illness - Caretaker** | ☐ **Incarceration - Caretaker** |
| ☐ **Physical Abuse - Non-Caretaker** | ☐ **Poverty/Lack of Resources** | ☐ **Substance Abuse - Caretaker** |

**Alleged Perpetrator:** **Age:**

**Relation to Child:** ☐ Biological Parent ☐ Step Parent ☐ Adult Relative ☐ Adult Non-relative ☐ Sibling ☐ Peer ☐ Other (Specify):

**DCP&P Substantiated?** ☐ Yes ☐ No ☐ Pending Date:

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**Original allegation (as reported to DCP&P):**

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**PAST ABUSE ALLEGATIONS:**
**Has family had past involvement with DCP&P:** ☐ **Yes** ☐ **No** **or** **Prosecutor's Office?** ☐ **Yes** ☐ **No**

**Allegation(s):** **Date:** **Alleged Perpetrator:** **Relation to Child:**

**DCP&P Substantiation**: ☐ **Yes** ☐ **No**

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**MEDICAL and DEVELOPMENTAL HISTORY:**

**Primary Healthcare Provider:** **Date last seen:**

**Address:** **Phone Number:** **Fax:**

**Any Current Medical Problems:**

**Current and Past Medications (Medical & Psychiatric):**

NAME: DOSE: PRESCRIBED BY: WHEN STARTED/ENDED:

**Current School or Daycare:** **Grade:**

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**MENTAL HEALTH SERVICES RECEIVED:**

**Has the child ever required Psychiatric Hospitalization:** ☐ Yes Date(s): ☐ No

**Is the child currently receiving therapy?** ☐ Yes ☐ No **If yes, where?**

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**BEHAVIORAL CHANGES (Please denote with a check if the child is exhibiting any behavioral problems):**

☐ Wetting Bed or Clothes ☐ Bed or Clothes Soiling ☐ Fire Setting ☐ Substance Use ☐ Cutting
☐ Suicidal Behavior ☐ Sexualized Behavior ☐ Other Behavior Problems (Please Explain):

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**CHILD'S BIOLOGICAL SIBLINGS:**

NAME GENDER DOB CURRENT LOCATION