Children's Services Council of Broward County
Our Focus is Our Children.

FAMILY STRENGTHENING REFERRAL FORM

DATE:

Individual Initiating Referral: **Agency:**

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

EMAIL ADDRESS:

FSFN #:

Supervisor Name: **Phone:**

EMAIL ADDRESS:

BSO ☐ Self ☐ School ☐ Other FS Agency ☐ Other: (SPECIFY)

Agency Referring To: Broward Children Center

- ☐ Achievement and Rehabilitation Center (ARC)
- ☐ Boys Town
- ☐ Camelot Community Care FFT
- ☐ Center for Hearing and Communication
- ☐ Children's Harbor
- ☐ Children's Home Society
- ☐ Community Based Connections
- ☐ Family Central NPP
- ☐ Family Central PAT
- ☐ Gulf Coast
- ☐ Healthy Mothers/ Healthy Babies
- ☐ Henderson MST
- ☐ JAFCO MST
- ☐ Gerena and Associates
- ☐ Kids In Distress (KID FIRST)
- ☐ Memorial Healthcare System
- ☐ Smith Community Mental Health
- ☐ The Starting Place FFT

	Last Name	*First Name*	*MI*		
Target Child:				**DOB:**	**AGE:**

Address:		**City:**	**Zip:**	**Phone (Home):**	
				****Cell:**	

Gender: Female		**Race:**		**Language:**	
Social Security Number:		**Client Identification Number (CID):**			
School:		**Telephone:**		**Grade:**	

Legal Guardian(s):

Name:		**SS#**		**Relationship to Client:**	
Name:		**SS#**		**Relationship to Client:**	

Name of Siblings	GENDER	DOB	SS#

Number of adults:	**Number of children:**	**Total Family Members:**	

EXPLAIN REFERRAL REASONS/ ABUSE CALL ALLEGATION: ***ATTACH ABUSE REPORT
Has a Legal Sufficiency staffing been held or is scheduled? Unknown
FINDINGS of Legal Sufficiency Staffing:
Is ChildNet involved with the family? No
If Yes, Provide Child Advocate Information.
Name:
Phone #:
Email:
Has a referral been made to CPT for current allegations? No
Describe Findings/ Recommendations:

Has CPT been involved with the family in the past?	
If YES, describe findings/recommendations:	
*** ATTACH CPT REPORTS, IF APPLICALBLE	
HAS THE FAMILY RECEIVED PREVIOUS COUNSELING SERVICES/PROGRAM? Homebuilders If Yes, please explain:	

Are there current Substance Abuse Concerns? If YES, Has a referral been made for services? To Where: _____ When: _____ By Whom: _____ Is FIS involved? YES NO	**Describe SA concern:**
Are there current Domestic Violence Concerns? If YES, Has a referral been made for services? To Where: _____ When: _____ By Whom: _____ Is WID involved? YES NO	**Describe DV concern:**

	***INCLUDE COPIES OF ALL REFERRALS TO SA and DV SERVICES		
PRIOR ABUSE REPORTS ON FAMILY? Yes If YES, how many #:			**FINDINGS: verified**
Date:		Allegation Type:	
Date:		Allegation Type:	
	***IF PRIORS ON FAMILY, PLEASE INCLUDE ALL PRIOR ABUSE REPORTS WITH REFERRAL		

DIRECTIONS TO THE HOME/ BEST TIME TO CALL:

Please describe any safety concerns for the in-home provider.

RECEIVING AGENCY USE ONLY:

Referral Received By: _____ Date: _____

Assigned To: _____ Date: _____

Reason if Referral Returned as Inappropriate: _____