



Maryland Department of Human Services  
Post-Permanency Program

### Therapeutic Services Referral Form

<b>Referral Services:</b>	<input type="checkbox"/> Interracial Adoption Support Group <input type="checkbox"/> Post-Permanency Support Group <input type="checkbox"/> Post-Permanency Counseling	
<b>Date of Referral:</b>		
<b>Referred By:</b>		
Title:		
Agency:		
Address:		
Phone Number:	Cell:	Work:
Email Address:		
<b>Supervisor Name:</b>		
Supervisor Address:		
Supervisor Phone Number:	Cell:	Work:
Supervisor Email:		
Reason for referral:		
Is the child aware of the referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the child's current caregiver aware of the referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No	



DEMOGRAPHICS	
Child/Youth's Name:	
Child/Youth's Preferred Name:	
Date of Birth / Age	Date of Birth: _____ Age: _____
Preferred Pronouns:	<input type="checkbox"/> He/him <input type="checkbox"/> She/her <input type="checkbox"/> They/them
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex
Gender Identity:	
Preferred Language:	
Country of Origin:	
Race:	<input type="checkbox"/> African <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not Listed: _____
Ethnicity:	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
EDUCATION	
School Name:	
Address:	
Phone Number:	
Grade:	
Special Education:	<input type="checkbox"/> Yes <input type="checkbox"/> No
IEP Code:	<input type="checkbox"/> Emotional <input type="checkbox"/> Learning <input type="checkbox"/> Combined
504 Plan:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral Concerns in School:	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of school suspensions/expulsions:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of schools attended since Kindergarten: _____	

PRIOR PLACEMENT INFORMATION	
Reason for Child Welfare Involvement: (Check all that apply.)	Abuse: <input type="checkbox"/> Emotional <input type="checkbox"/> Physical <input type="checkbox"/> Sexual  Neglect: <input type="checkbox"/> Physical <input type="checkbox"/> Medical <input type="checkbox"/> Educational <input type="checkbox"/> Abandonment  <input type="checkbox"/> Other (explain):
Year of placement in child welfare:	Click or tap to enter a date.
Prior Guardianship/Adoption/Placement Disruption?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
CURRENT PLACEMENT INFORMATION	
Is this an open adoption?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child visit Birth Mother?	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ Supervised: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child visit Birth Father?	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ Supervised: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child visit with Siblings?	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ Supervised: <input type="checkbox"/> Yes <input type="checkbox"/> No

# ADOPTIONS TOGETHER



Contact with other family members?	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____ Supervised: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe with whom and relationship:		
Birth parent's impact on adoption:			
<b>FAMILY INFORMATION</b>			
Parent 1 Name:			
Address:			
Phone Number(s)	Phone 1:	Phone 2:	E-mail:
Parent 2 Name:			
Address:	<input type="checkbox"/> Same as Parent 1		
Phone Number(s)	Phone 1:	Phone 2:	E-mail:
Date of Placement:	Click or tap to enter a date.		
Date of Adoption Finalization:	Click or tap to enter a date.		
<b>THERAPEUTIC SERVICES</b>			
Is the child currently receiving individual counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No How often? Provider (Name, Agency, Address, Phone Number):		
Is yes, what are the issues being addressed?			
Does the current provider know about this referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:		

# ADOPTIONS TOGETHER



<p>Is the child and their family receiving family therapy?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No          How often? _____          Provider (Name, Agency, Address, Phone Number):</p>
<p>Which family?</p>	<p><input type="checkbox"/>Biological Parents Guardianship Parents Foster Parents  <input type="checkbox"/>Pre-Adoptive Parents  <input type="checkbox"/>Adoptive Parents</p>
<p>If yes, what are the issues being addressed?</p>	
<p>Does the current provider know about this referral?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No          If no, please explain:</p>
<p>Has or is the child participating in any support groups?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No          How often? _____          Date of participation: _____          Provider (Name, Agency, Address, Phone Number):</p>
<p>Has or is the child's family participating in a support group?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No          How often? _____          Date of participation: _____          Provider (Name, Agency, Address, Phone Number):</p>



PROFESSIONALS		
<b>Foster Care Social Worker:</b>		
Agency:		
Address:		
Phone Number (s)	Cell:	Work:
Email Address:		
Supervisor Name:		
Supervisor Address:		
Supervisor Phone Number:	Cell:	Work:
Supervisor Email:		
<b>Adoption Social Worker:</b>		
Agency:		
Address:		
Phone Number:	Cell:	Work:
Email Address:		
Supervisor Name:		
Supervisor Address:		
Supervisor Phone Number:	Cell:	Work:
Supervisor Email:		
<b>Guardian Ad Litem:</b>		
Agency:		
Address:		
Phone Number:	Cell:	Work:
Email Address:		
Judge:		
Address:		
Phone Number:	Cell:	Work:
Email:		
<b>Court Appointed Special Advocate:</b>		
Address:		
Phone Number:	Cell:	Work:
Email:		



Attachments (check what is included in referral)		
Current Social Summary	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bonding/Attachment Study	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Most Recent Court Order	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Most recent Court Report	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Referring Caseworker Signature: \_\_\_\_\_

Supervisory Social Worker Signature: \_\_\_\_\_

**Please submit completed referral and attachments to:**

Melanie Geddings-Hayes, LCSW-C Director of Clinical Services  
[melanie@familyworkstogether.org](mailto:melanie@familyworkstogether.org), 202-629-0204 (office), 202-526-4803 (fax)