Social Medical History Referral

Thank you for choosing Children's Home to assist in your Social Medical History writing. We appreciate your time in helping us gather information regarding the youth you are referring. If you have any questions about this referral, please contact our staff at csr@chlss.org.

Youth Information

Please share information about the youth you are referring for SMH completion services. If you are referring a sibling group, please complete a separate referral for each service.

Name (First, Middle & Last): _____

Other Names/Preferred Name: _____

Date of Birth: _____

Youth Pronouns: _____

Gender: _____

Sexual Orientation/Gender Identity: _____

Physical Description

Hair color _____ Eye color _____ Skin Color _____

Race(s)/Ethnicity: Select | Select | Select

Does ICWA apply? Select

Tribe Information:

Referring Worker Information

Please include information for the County Worker who will be the main point of contact for the Social/Medical History

Referring Social Worker Name and Role: _____

Email: _____

Phone Number: _____

Birth Family and Caregiver Information

Please note that CH will be reaching out following the referral to get signed releases for each contact listed below.

Are siblings being referred? Select

Sibling Information: Include names for ALL siblings (those who are in foster care and those who may be adults or still residing with birth family) *If a social medical history is being requested for any of the siblings, please complete a **separate** referral and indicate if ALL Birth Parent & PAST Placement information is the same. Please list names & DOB's of siblings

Children's Home

Birth Mother Name and Contact Information:

Enter all contact information that is known. Email and phone are preferred.

Birth Father Name and Contact Information:

Enter all contact information that is known. Email and phone are preferred.

Former Adoptive Family (if applicable) Name and Contact Information:

Enter all contact information for former adoptive families (if applicable). Email and phone are preferred.

Youth's Current Placement Type: Select

Current Caregiver Name and Contact Information:

Please Include Phone, Email and Physical Address

Will translation be needed to speak with any of the listed contacts? No

Provide Additional Information about translation:

Please share name and primary language for any contacts who may need translation for contact.

Additional Contact Information

Please include information for any additional relatives, service providers, or current/past case workers who may have important information relating to this child's social and medical history. Please note that CH will be reaching out following the referral to get signed releases for each contact listed below.

Name and Role/Relation: _____

Contact Information (phone/email): _____

Name and Role/Relation: _____

Contact Information (phone/email): _____

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Name and Role/Relation: _____

Contact Information (phone/email): _____

Name and Role/Relation: _____

Contact Information (phone/email): _____

Will translation be needed to speak with any of the listed contacts? Select

Provide Additional Information about translation:

Please share name and primary language for any contacts who may need translation for contact.

Verification and Signature

Please sign below to indicate county approval for completion of this service by Children's Home. By signing below, your county agrees to pay the agreed upon billing rate for this service.

Signature: _____

Date: _____

Role: _____

A One Drive link will be sent to you following this referral to begin uploading documents. The following documents will be helpful in completing the SMH document:

- Birth Certificate
- Immunization Record
- Most recent GAL and SW Report to Court
- CHIPS Petition
- Out of Home Placement Plan
- Medical Records- Birth and Ongoing
- TPR Petition and Filling (if applicable)
- Contact Information for Family (birth, foster adoptive)
- Education Records (Schools attended, IEP/504 Plans)
- Developmental Screenings
- Previous SMH
- Psychological or Psychiatric Evaluations
- Diagnostic Assessments
- Dental Records
- Therapeutic Progress Reports

You can email any questions to csr@chlss.org. Additional documentation may be requested through email upon receipt of this referral.