



Referral Placement Packet

Date of Referral: ____ / ____ / ____

Name of Potential Client: _____ DOB: ____ / ____ / ____ please circle one: Male or Female

Referring Name _____ Phone _____ Agency _____

Date Placement Needed ____ / ____ / ____

Program Interest: (circle all that apply) TRCCF/Day Tx/In-Home/Diagnostic Assessment/Outpatient/School Only

Date Placement Needed ____ / ____ / ____ Court order: please circle Yes or No

Why is Human Services involved? _____

Other agencies involved: _____

Reason for placement or change in placement: _____

Where is the child now? _____

Estimated Length of stay: _____

Presenting issues: _____

Legal: (please circle all that apply) D&N/Delinquency/Voluntary

Family History Information and Who is Involved Currently: _____

Current Problem Areas: (please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Psychotic Symptoms | <input type="checkbox"/> Self-destructive Behavior |
| <input type="checkbox"/> Assaultive Behavior | <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Gang Involvement | <input type="checkbox"/> Runaway Behavior | <input type="checkbox"/> Perpetration |

Trauma History: (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Emotional Abuse |
| <input type="checkbox"/> Physical Neglect | <input type="checkbox"/> Emotional Neglect | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Parents Substance Abuse | <input type="checkbox"/> Parent Mental Illness | <input type="checkbox"/> Parental Loss |



History of delinquent behaviors and charges: _____

History of Aggression: _____

Previous placements: (how many, what kind, etc) _____

Previous interventions that have been helpful: _____

Education: _____

School District: _____ Last School attended: _____

Special Ed: (please circle one) Yes or No (If yes, please fax IEP with packet)

History of school performance: _____

Medical: _____

Current Medications: _____

Allergies: _____

Medical Concerns: _____

Return Form To:

Attn: Admissions

Denver Children's Home

Main number- 303-399-4890

Direct Number- 720-881-3405

Fax- 303-962-2661

admissions@denverchildrenshome.org