

DHS EVALUATION REFERRAL REQUEST

Please complete this form so we may review the information to determine if we can help you. **Fax the completed form to the Children's Program (503 452-0084)** and someone will call you to discuss the case, and set up a date and time for the evaluation, if appropriate.

Parent/Child to Be Evaluated: _____

Client Recipient ID #: _____ **Age/DOB:** _____

Client's Primary Language: _____

NAMES/AGES OF FAMILY MEMBERS:

Mother: _____

Father: _____

Siblings: _____

Significant Other: _____

WITH WHOM DOES THE CHILD LIVE?

FOSTER PARENT(S) NAME AND PHONE NUMBERS:

WILL FOSTER PARENT ATTEND EVALUATION?

WHO WILL TRANSPORT THE CHILD?

IF FOSTER PARENT WILL TRANSPORT, MAY WE MAKE AN APPOINTMENT REMINDER CALL? YES ___ NO ___

PREVIOUS TESTING? YES ___ NO ___ IF YES, WHEN? _____ WHERE? _____

DOES CHILD HAVE AN IEP? YES ___ NO ___

REFERRAL QUESTIONS (CHECK ALL THAT APPLY):

___ Current Functioning (intellectual, emotional, academic, developmental)

___ Treatment or Special Services Needed

___ Diagnosis

___ Ability to Parent

___ Strength/Bond of Relationship Between: _____

___ Long-term Placement Needs

___ Ability to Transition to a Permanent Home

___ Placement Considerations (e.g., residential treatment)

___ Divorce Issues/Custody Determination

___ Other Questions Not Addressed

SIGNIFICANT HISTORY/CONCERNS:

NEXT SCHEDULED COURT HEARING?

TIMELINE/SCHEDULE CONSTRAINTS

OTHER SPECIAL CONSIDERATIONS

___ Parent/Child or Sibling Interaction

Purpose of Interaction? _____

Who Would Be Involved? _____

CASEWORKER: _____ **BRANCH** _____

I AGREE TO RECEIVE THE COMPLETED REPORT VIA EMAIL. YES _____ NO _____

EMAIL: _____

PHONE: _____ **FAX** _____