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| Date of Referral: | | | | |
| **Family Referred for Services** | | | | |
| Parent(s): | | | | |
| Primary Phone: | | Secondary Phone: | | |
| Primary Email: | | Secondary Email: | | |
| Physical Address:  County: | | Mailing Address: | | |
| Marital Status: | | Parent(s) Race: | | |
| **Child’s Name** | **DOB & Gender Identity** (i.e., Male, Female, Transgender, Non-Binary) | | **Relationship** (i.e., Adopted Child, Foster Child, Biological Child) | **Race/Ethnicity** |
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| **Referral Information For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Check one:**  **The family referred has a legal, finalized adoption**  Actual or approximate date of finalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Type of Adoption**  **Foster Care**   **Domestic**   **International** | | | | |
| **Reason for Referral & Current Services**  Please provide a brief description of why you are referring the family to post adoption services and current needs of the family (i.e.: training/education, peer support, family events, behavior challenges, birth family connection):  Please list any current services accessed by the family: | | | | |
| **If other than self-referral, please provide the following information:**   * I have explained Post Adoption Services to this family and the family knows to anticipate follow-up from a worker who will enroll them in services.   Worker: Phone: \_\_\_\_\_\_\_\_  E-mail: \_\_\_\_\_\_\_\_\_\_\_\_ Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| **Please send all referrals to Shannon Shepherd- Fax: 276.623.0002**  **Email:** [**SShepherd@depaulcr.org**](mailto:SShepherd@depaulcr.org) |

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| **Staff Use Only**  **Check one:**  Piedmont Region Referral  Date Assigned:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Assigned Case Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Western Region Referral  Date Assigned: \_\_\_\_\_\_\_\_\_\_\_\_\_  Assigned Case worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

