CFS 440-6
Rev 9/99

Department of Children and Family Services
DCFS Referral for Adult Alcohol and Other Drug Treatment Services
(to be completed by DCFS/POS worker)

Name of Referral:	Date of Birth:
Address:	Phone:
Marital Status:	DCFS Case #:

Adults Living in the Household	Relationship to Client
1)	
2)	
3)	
4)	
5)	
6)	

Children	Age	Sex	Placement Information
1)			
2)			
3)			
4)			
5)			
6)			

Child Welfare Worker's Name (print):	Worker's Phone:
Worker's Signature	Date of Referral:
Supervisor's Name (print):	Supervisor's Phone:
DCFS Office or POS Agency Name:	

Attach copies of: Adult Substance Abuse Screen (CFS 440-5)
Consent for Disclosure (CFS 440-7)