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Rev 05/2009

State of Illinois
Department of Children and Family Services

# DCFS Regional Nurse Referral Form

Directions: Enter all requested information and e-mail the completed form via Outlook to "nurseref" or fax to the attention of the Child Welfare Associate Specialist at 866-531-1459. Incomplete and handwritten referrals will not be processed.

## CASE INDENTIFICATION INFORMATION

| | |
|---|---|
| CHILD'S NAME: | ☐ Male ☐ Female |
| PARENT'S NAME: | CHILD'S DATE OF BIRTH: |
| Address: | Home Telephone: |
| | Work Telephone: |
| | CYCIS ID: |
| Legal Status of Child: Date: | SACWIS ID: |
| Family's Primary Language: | SCR#: |

Complete the following section if the child has a substitute caregiver.

| | |
|---|---|
| Caregiver's Name: | Work Telephone: |
| Caregiver's Relationship to Child: | Home Telephone: |
| Caregiver's Address: | Cell Telephone: |

## REFERRAL INFORMATION

| | |
|---|---|
| Worker's Name: | Telephone: |
| Address: | Fax Number: |
| | R/S/F: |
| Supervisor's Name: | Telephone: |
| ☐ DCFS<br>☐ POS-Agency Name: | |

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CHILD'S NAME:_________________________________________ DATE OF BIRTH:___________________

Complete the following section if the person making the referral is different than the assigned caseworker.

| Name: | Telephone: |
|---|---|
| Address: | Fax Number: |
| ☐ DCFS ☐ POS ☐ DCP ☐ HealthWorks ☐ Regional Nurse ☐ DSCC | |

## CHILD SPECIFIC INFORMATION

| Child's Primary Care Physician: | Telephone: |
|---|---|
| Address: | Fax Number: |

*REASONS FOR REFERRAL (CHECK ALL THAT APPLY)*

| ☐ **Emergency** | ☐ Special Health Care Needs | ☐ Psychiatric Diagnosis / Medication Regimen |
|---|---|---|
| ☐ Consultation | ☐ Medication Information | ☐ Discharge Assessment (Hospital) |
| ☐ Notification Only | ☐ Medical Record Review | ☐ Health Care Plan Guidance |
| ☐ Home Assessment | ☐ Physician Contact | ☐ Health Resource Needed |
| ☐ Site Visit – Location of Visit: | | |
| ☐ Staffing/CAYIT – Date, Time & Location: | | |
| ☐ Casual Inquiry – Information Needed: | | |

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CHILD'S NAME:________________________________________ DATE OF BIRTH:__________________

☐ Medical Information Needed – Specify if Known:

PROBLEM(S)/DIAGNOSIS(ES):

☐ Child Hospitalized – Hospital Name, Address, Contact Person's Name and Telephone:

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CHILD'S NAME:________________________________________ DATE OF BIRTH:__________________

ATTACHED DOCUMENTATION

| |
|---|
| ☐ Diagnosis |
| ☐ Current Treatment Plan |
| ☐ Individual Education Plan |
| ☐ Hospital Discharge Summary |
| ☐ Psychological/Psychiatric Reports |
| ☐ System of Care or Specialized Designation |
| ☐ Current Progress Reports/ Treatment Summary |
| ☐ Statement of services that are in process of being implemented |
| ☐ Medical Unusual Incident Reports |
| ☐ Other – Specify: |

_____________________________________________

*Signature and Date of Referring Worker*

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CHILD'S NAME:________________________________________ DATE OF BIRTH:__________________

## NURSE'S INFORMATION

| Date Referral Received: | Assigned To: |
|---|---|
| Date Referral Received by DCFS Nurse: | Time |

☐ **Referral Accepted** ☐ **Referral NOT Accepted**

Using the Nursing Process document your initial nursing assessment; NANDA Nursing Diagnosis; interventions, evaluations/recommendations, and plans for the services required by a child with special health care needs **OR**; Document your reasons(s) for NOT accepting the referral using the Nursing Process for your initial nursing assessment and applicable NANDA Nursing Diagnosis.

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**DCFS Regional Nurse Referral Form**

CHILD'S NAME:_______________________________________ DATE OF BIRTH:__________________

_________________________________________________________________________

*Nurse's Signature, Date and Region*