CFS 2016
4/2003

State of Illinois
Department of Children and Family Services

CFS: _____
Child Name: _____
Child Id#: _____
R/S/F: _____

CHILD CLINICAL SUMMARY

Date of Presentation: _____

DOB: _____ **Age:** _____ **Gender:** _____

Race/Ethnicity: _____ **Language:** _____

Permanency Goal: _____ **TPR:** ☐ **Yes** ☐ **No** **Sexual Behavior Problems:** ☐ **Yes** ☐ **No**

Family Involvement (include parent and sibling visitation): _____

Current Placement: _____ **Length of Stay:** _____

Most Current IQ: _____ **Anticipated Discharge Date:** _____

Diagnosis: _____ **Medication(s):** _____

Youth's strengths, interests and or hobbies (must list at least three): _____

Educational Summary (grade, type of programming- IEP or 504 plan, needs): _____

Emotional/Behavioral Needs: _____

Service Needs Upon Discharge: _____

Medical Needs: _____

Caseworker name: _____ **Supervisor Name:** _____

Phone Number: _____ **Phone Number:** _____