

CFS 2016
4/2003

State of Illinois
Department of Children and Family Services

CFS: _____

Child Name: _____

CHILD CLINICAL SUMMARY

Child Id#: _____

R/S/F: _____

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: _____