



2750 West Bennett Springfield, MO 65807
 Phone (417)865-CARE Fax (417) 865-3081

Referral Form

Date: _____ Time: _____ am/pm Agency: _____
 Referring agent name: _____ Position: _____
 Address: _____ Phone #: _____

Was the parent(s) notified about this referral? ___ Yes ___ No

Parent(s)/Legal Guardian: _____
 Address: _____ City: _____ County: _____
 Home Phone: _____ Cell Phone: _____ Message: _____

How did you hear about us? _____

Referral Reasons (please check all that apply)

- Homeless
- Drug or alcohol treatment (inpatient programs)
- Domestic Violence
- Mental Health Needs
- Parent, sibling, or guardian medical treatment (inpatient, outpatient, and/or home recovery)
- Child at risk of abuse or neglect
- Birth plan for single mother
- Short term incarceration in limited circumstances
- Other _____

Brief summary

Child(ren) being referred for placement:

Name of Child	Date of Birth	Gender	Comments on Special Needs

Approximate Length of Stay

- 24 hours 2-5 days 1 week 2 weeks 3 weeks 30 days

Medications: _____
