

Referrals in WISCONSIN SEND TO

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Referrals in MINNESOTA SEND TO

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*We create permanent connections to
loving and stable families*
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ANU FAMILY SERVICES REFERRAL FORM

Taken by: _____ Intake Date: _____

Type: ___Adult ___Emergency ___Respite ___Shelter ___Short-Term F.C. ___ Treatment F.C.

Child's Name: _____ **DOB:** _____

Race: _____

Referring Social Worker: _____ **Phone:** _____

Email address: _____ **County:** _____

Geographic Consideration: _____

When is Placement Needed: _____

Potential Families: _____

Anu Social Worker Assigned: _____

Follow up: _____

Behavior/Current Issues

Child's Strengths & Positive Characteristics: _____

Presenting Problems:

- | | | |
|--|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Runaway |
| <input type="checkbox"/> AODA | <input type="checkbox"/> Emotional Abuse/Neglect | <input type="checkbox"/> Sexually abused |
| <input type="checkbox"/> Attachment Issues | <input type="checkbox"/> Enuresis/Encopresis | <input type="checkbox"/> Sexually active |
| <input type="checkbox"/> Cognitively Delayed | <input type="checkbox"/> Fire setting | <input type="checkbox"/> Sexually inappropriate |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Gang Affiliation | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Delinquency | <input type="checkbox"/> Medical Concerns | <input type="checkbox"/> Suicidal tendencies |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Physically Aggressive | <input type="checkbox"/> Verbally aggressive |
| <input type="checkbox"/> Destructive to Property | <input type="checkbox"/> Physically Abused | <input type="checkbox"/> Other |

Behaviors the foster parents will need to work with: _____

History of physical aggression: _____

Can not be placed with younger children.

Sexual Aggression: No Yes (see page 5)
Court Dispositions: CHIPS JIPS Delinquent Ch. 51 Voluntary TPR
Custody/Guardianship: _____

Current Residence: _____

Prior Placements:

- | | | | |
|--|--------------------------------------|---|----------------------------------|
| <input type="checkbox"/> AWOL | <input type="checkbox"/> Detention | <input type="checkbox"/> Hospital | <input type="checkbox"/> Respite |
| <input type="checkbox"/> Adoptive Home | <input type="checkbox"/> Foster Home | <input type="checkbox"/> Inpatient treatment facility | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> CCI Placement | <input type="checkbox"/> Group Home | <input type="checkbox"/> No prior placements | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Corrections | <input type="checkbox"/> Home | <input type="checkbox"/> Relative's Home | <input type="checkbox"/> Other |

Name of Prior Placement	Dates	Status (progress, reason for leaving)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Psychiatric

Diagnosis: _____

Medical needs _____

Physical Disabilities/Allergies: _____

Medication: _____

Tobacco Use: _____

Chemical abuse or treatment: _____

Education

Last school attended: _____ Grade level: _____

___ Reg Ed ___ ED ___ LD ___ CD ___ IQ ___ Day Tx

___ Self-contained classroom ___ Partial Mainstream ___ Total Mainstream

History of: ___ Truancy ___ Suspension ___ Expulsion

Ability/Achievement: _____

Behavior issues: _____

Activities: _____

Other: _____

Placement Planning/Family Connections

Parent/Guardian Names: _____

Address/Phone: _____

Biological/Adopted Parents Race:: _____

Family Circumstances: _____

Long range plans: _____

Anticipated length of placement: _____

Child's attitude about placement: _____

Family involvement: _____

Co-Professionals: _____

Are there siblings in care? ___ Yes ___ No

Are there other important relationships for youth. ___ Yes ___ No

Current therapist: _____

Treatment requirements: _____

Sexually Offending Behaviors

Inappropriate with ___self ___males ___females ___animals

Number of times offended:___ Number of victims:___ How recently_____

Age and sex of victim(s) at time of offense:_____ Age Difference(s)_____

Relationship to the victim(s):_____

Evidence of: ___Prior Planning_____

___Coercion_____

___Use of force_____

Details of the offense(s):_____

Reported ___Yes ___No_____

Investigated ___Yes ___No_____

Founded ___Yes ___No_____

Charged ___Yes ___No_____

History:___Socialized ___Aggressive ___Under-socialized

___Ritualistic Behaviors/Obsessive-Compulsive ___Non-aggressive

___Other

Treatment received:_____

Successful___ Unsuccessful___

Current program/safety plan:_____

Request police reports, court reports, treatment reports: _____Date requested

