

<h2 style="margin: 0;">CANS Referral Form</h2> <p style="margin: 0;">(Child and Adolescent Needs and Strengths)</p>	<p style="margin: 0;">Philadelphia</p> <p style="margin: 0;">Department of Human Services</p>
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TO BE COMPLETED BY THE REFERRAL SOURCE

CHILD INFORMATION

Case Name:		DHS Case Number and Suffix:	
Child Name:		Social Security Number:	
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Accept for Service Date:	Date of Most Current Placement/Hospitalization:
Child's Current Service: (please check one) <input type="checkbox"/> NA, child is at home <input type="checkbox"/> Shelter <input type="checkbox"/> Foster Care <input type="checkbox"/> Treatment Foster Care <input type="checkbox"/> Group Home <input type="checkbox"/> Group Home/MR <input type="checkbox"/> Institution <input type="checkbox"/> Residential Treatment Facility <input type="checkbox"/> Hospital – Inpatient Unit <input type="checkbox"/> Other, specify: _____		Provider of Current Service:	
		Child's Current Address (including zip code):	
		If the child is currently in the hospital, please complete:	
		Hospital Name:	
		Hospital Address:	

**CONTACT INFORMATION
(THIS SECTION MUST BE COMPLETED)**

DHS Worker:	Phone #: () Ext.
DHS Supervisor:	Phone #: () Ext.
Name & Phone # of the Provider Social Worker and/or Supervisor (OR the Person who knows specific information regarding the Child's Current Situation)	
Name & Title:	Phone #: () Ext.

REFERRAL SOURCE

Referral Source: (check one)	Name	Phone	Ext.
<input type="checkbox"/> CBH Care Manager		()	
<input type="checkbox"/> CRU Screening Unit Worker		()	
<input type="checkbox"/> DHS Case Manager		()	
<input type="checkbox"/> PBC Reconsideration Staff (DHS)		()	
<input type="checkbox"/> GFC Provider Staff		()	
<input type="checkbox"/> TFC Provider Staff		()	
<input type="checkbox"/> Group Home Staff		()	
<input type="checkbox"/> Institution Staff		()	
<input type="checkbox"/> Residential Treatment Facility Staff		()	
<input type="checkbox"/> Hospital – Inpatient Unit Staff		()	
<input type="checkbox"/> Other, specify:		()	

Most Recent Evaluation	Date	Attached to Referral	
		Yes	No
<input type="checkbox"/> Psychiatric		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psychological		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bio-Psychosocial Assessment		<input type="checkbox"/>	<input type="checkbox"/>

REASON FOR REFERRAL: (check ONE and add comments)

<input type="checkbox"/> Step up from Home	<input type="checkbox"/> Step down from Group Home
<input type="checkbox"/> Step up from SCOH	<input type="checkbox"/> Step down from Institution
<input type="checkbox"/> Step up from Kinship	<input type="checkbox"/> Step down from RTF
<input type="checkbox"/> Step up from PBC	<input type="checkbox"/> Step down from Hospital
<input type="checkbox"/> Step up from General Foster Care	
<input type="checkbox"/> Step up from Shelter	<input type="checkbox"/> Check this box if the child is in a Pre-Adoptive Home

Comments: