UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

CHILD REFERRAL FORM

Date of Call/Referral: _____

THE CARE CLINIC AT THE UNIVERSITY OF MARYLAND CENTER FOR FAMILIES

Referrals can be made via phone at **410-706-4869**; via fax at **410-706-3017**; or via email to **careclinicreferrals@peds.umaryland.edu**

Name of Referred: _____ DOB: _____

Gender: ○Male ○Female ○Other _____ Race/Ethnicity: _____

Secondary Victim(s) Names and DOB: _____

_____

Caregiver Name & DOB: _____

Relationship to Child: _____ Legal Custody of Child: ○Full ○Partial ○Shared ○None

Address: _____ City: _____ State: _____

Zip code: _____ County: _____ Phone Number: _____

Email Address: _____

Other Legal Guardian: _____ Relationship to Child: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone Number: _____

Email Address: _____

Referral Source

Name: _____ Agency: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

Other Agencies Involved:

Name: _____ Agency: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

(See other side)

Medical Issues: _____ Medications: _____

School Name: _____

Grade: _____ IEP/other plan/services (please describe): _____

Type of Abuse: (check all that apply)

○Sexual Abuse ○Physical Abuse ○Neglect ○Domestic Violence ○Sex Trafficking

Alleged Perpetrator & Relationship: _____

Date of Incident: _____ Date of Incident Disclosure: _____

Reason for Referral (brief summary of observed behavioral problems, symptoms, etc.)

_____

_____

_____

_____

Symptoms: (please check all that apply)

○ Fire setting	○ Abuse of animals	○ Psychiatric hospitalizations
○ Suicidal gestures or ideation	○ Violence toward others	○ Speech/developmental delays
○ Psychosis	○ Sexual behavioral concerns	○ Physical aggression
○ Drug/alcohol abuse	○ Sleep disorders	○ Nightmares/flashbacks
○ Hallucinations	○ Tantrums	○ Academic/behavior problems
○ Anxiety	○ Depression	○ Irritability
○ Disordered eating	○ Low self-esteem	○ Mood fluctuation

Is the child currently in treatment? ○Yes ○No

If yes, list where & explain reason for treatment:

_____

_____

Type(s) of Services requesting: (please check all that apply)

○ Intake Evaluation (diagnosis, treatment recommendations)

○ Individual Therapy ○ Group Therapy ○ Family/Couple Therapy

○ Psychological Evaluation (for academic/cognitive functioning)

○ Psychiatric Evaluation **(only for care clinic clients)**

***The Care Clinic does NOT provide forensic assessments.**