

**MEDICAL REVIEW BOARD REFERRAL**

*Please Type or Print Clearly*

**TO:** Chairperson, Medical Review Board

**FROM:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **TELEPHONE NUMBER:** \_\_\_\_\_

CHILD'S NAME	CASE NUMBER	DATE OF REFERRAL	DATE OF BIRTH
RELIGION	ETHNICITY	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

**LEGAL STATUS**

Committed (Abused / Neglected)

Committed (Delinquent)

Dual Commitment (Abuse/Neglect/ Delinquent)

BEGIN DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Statutory Parent

Committed / FWSN

Not Committed

END DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Order of Temporary Custody

96 Hour Hold

Other (Specify): \_\_\_\_\_

Has the child's parent (birth or foster parent) been contacted by the Social Worker?

Yes  No

**PLACEMENT TYPE**

Relative Placement

Pre-Adoptive

Group Home

Residential Facility

Independent Living

Foster Home

Detention Correctional

Shelter

Hospital

Long Lane School

NAME OF FOSTER PARENT/FACILITY WHERE CHILD/YOUTH IS PLACED:		TELEPHONE NUMBER
PRIMARY HEALTH PROVIDER (LOCAL PHYSICIAN)		TELEPHONE NUMBER
SUB-SPECIALIST / CLINIC		TELEPHONE NUMBER
IS CHILD HOSPITALIZED NOW? <input type="checkbox"/> Yes <input type="checkbox"/> No	WHY?	
CURRENT MEDICATION		

Description of the situation requiring a decision: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Action Requested: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

REGIONAL OFFICE ADDRESS		FAX NUMBER
SOCIAL WORKER NAME	SIGNATURE	TELEPHONE NUMBER
SOCIAL WORK SUPERVISOR NAME	SIGNATURE	TELEPHONE NUMBER