Scioto Service Coordination Referral
Scioto County Family & Children First Council

Submit completed referral forms to: Scott Holstein, Scioto County FCFC Director at scott.holstein@scoesc.org 740-354-0226

Referral Date: _____ Name of Youth: _____

Date of Birth: _____ Gender: M☐ or F☐

Referring Person/Agency:_____

Phone: _____ Email: _____

Parent/Guardian Information:

Name/Role: _____Email: _____

Address: _____ City: _____

Home Phone: ( ) _____ Cell: ( ) _____

Name/Role: _____Email: _____

Address: _____ City: _____

Home Phone: ( ) _____ Cell: ( ) _____

Child Resides with:

☐ Mother ☐ Father ☐ Legal Custodian ☐ Foster Care ☐ Other

Siblings Living in the Home	Date of Birth

Other Adults living in the Home	Relationship to the Child

Presenting Risks and History/Reason for Referral

Check all known presenting risks:

☐	Suicidal Ideations, Attempts	☐	Impulsive Behavior	☐	Domestic Violence
☐	Self-injurious Behavior	☐	Hears Voices/Sees Things	☐	Homelessness
☐	Aggressive Behaviors Toward Others	☐	Eating Disorder	☐	Isolation, No natural Supports
☐	Cruelty Toward Animals	☐	Suspensions, Expulsions	☐	Parent with Serve Chronic Illness
☐	Fire Setting	☐	Truancy	☐	Availability of Weapons
☐	Physical Abuse, Sexual Abuse, and or Neglect (circle)	☐	Uses or has Used Drugs and/or Alcohol	☐	Depression
☐	Sexual Acting Out	☐	Bullying	☐	Other (please specify):
☐	Running Away	☐	Unrestricted Technology Access		

* Describe the child's at risk history and the reason for being referred for services:

Agencies Providing Services: (check all that apply)

____Child Protective Services Caseworker: _____

____Juvenile Court: Probation Officer: _____

____Developmental Disabilities SSA: _____

Diagnosis: _____

____Help Me Grow, Early Head Start, Head Start

Coordinator/Visitor/Teacher: _____

____Mental Health Agency _____

Therapist: _____ Agency: _____

Psychiatrist: _____ Agency: _____

Has the child had a psychological assessment?

☐YES or ☐NO Date: _____

Diagnosis:_____

Medications: _____

Additional systems providing support/services: *(agency name/contact person/phone & email)*

_____

_____

_____

_____

School Information

Home School: _____ School of Attendance: _____

Teacher's Name: _____ Email/Phone: _____
Does the child have an IEP? ☐ Yes or ☐ No Grade:_____

*Explain school behaviors and academics:

(any suspensions, grades, extra-curricular, etc.)

_____

_____

_____

_____

_____

Insurance

☐ Private Insurance? Provider: _____

☐ Medicaid? Managed Care Provider: _____
(ex: Molina, CareSource)

Primary Care Physician's Name: _____

Contact Information: _____

Check Services Recommended:

____Non-Clinical in-home parent/child coaching

____Non-Clinical parent support groups

____Parent Education

____Mentoring

____Respite Care (i.e. summer camps, family emergency)

____Transportation (i.e. cab/taxi fares, gas vouchers)

____Social/Recreational Activities

____Safety and adaptive equipment

____Structured activities to improve family functioning

____Parent advocacy

____Service coordination

Please list other services that may be needed:

_____

_____

_____

_____