FAMILY & CHILDREN FIRST COUNCIL OF TRUMBULL COUNTY
Wraparound Referral Form

Date: _____

Identified Youth's Name	Date of Birth	Race/Ethnicity	Gender	Adopted Y or N	Previously involved in Wraparound (Y or N)

Referred By: **Relationship to child:**

Email: **Phone:**

Briefly describe the reason for referral. What would you like to accomplish?	Social Security #

Strengths of the Youth and Family:

School	Grade	Educational Placement: (i.e. regular ed, special ed, home schooled etc.)

Is the youth on an IEP? ☐ Yes ☐ No Preferred Language: _____

Guardian Name:	Guardian Name:
Relationship to youth:	Relationship to youth:
Address:	Address:
City: State: Zip:	City: State: Zip:
Preferred Phone:	Preferred Phone:
Email:	Email:

Biological Parents' Names (if different than guardians): _____

Other household members:	DOB	Relationship	Adopted Y or N	School	Grade

Does youth have Medicaid? ☐ Yes ☐ No Name of Provider: _____
Does youth have Private Insurance? ☐ Yes ☐ No Name of Provider: _____
Primary Care Physician's Name: _____

Is youth in need of a Primary Care Physician? ☐ Yes ☐ No

FAMILY & CHILDREN FIRST COUNCIL OF TRUMBULL COUNTY
Wraparound Referral Form

Is youth currently out of the home (hospital, detention, treatment facility)? ☐ Yes ☐ No (If Yes, complete the following):	
Placement:	Contact:
Address:	Phone:
City: State: Zip:	Email:

Please Indicate the child's involvement in the following systems.

***Check *Current* if involved in the past 30 days. Check *History* if involved prior to 30 days. Check *both boxes* if they both apply.**

Current	History	System	Reason for Involvement	Provider Name(s)/Role(s)
☐	☐	**Board of DD**		
☐	☐	**Children Services**		
☐	☐	**Special Education**		
☐	☐	**Job and Family Services**		
☐	☐	**Mental Health**		
☐	☐	**Juvenile Court**		
☐	☐	**Addiction Services**		
☐	☐	**Hospital**		
☐	☐	**Early Intervention/HMG**		
☐	☐	**Other:**		

If court involved, check if the court has found the youth: ☐ Unruly ☐ Delinquent (criminal offense if an adult)

Behavioral Health Diagnoses: _____

Current Medications: _____

Check if History of Abuse: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect
Reports of sexual and/or physical abuse of the youth, **past or present.** (Professional must follow duty to report mandate if this event has not already been reported)

For FCFC office use only: ☐ Approved ☐ Denied		
Assigned to:	Date:	Additional Comments:

Revised 11/20