|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| The Care Clinic**um_childrens_pms** 520 W. Lombard St, Gray Hall, Ground FloorBaltimore, MD 21201Phone: 410-706-4869 Fax: 410-706-3017Child/Adolescent Referral FormDemographic Information

|  |  |
| --- | --- |
| **Child/Adolescent Name**: | Birth Date |
| Race/Ethnicity: | Gender: |
| Do any of the following apply to this child? (check all that apply)[ ] Deaf/hard of hearing [ ] Homeless [ ] Immigrant/refugee/asylum-seeker [ ] LGBTQ [ ] Veteran [ ] Limited English/ESL [ ] Disability (physical/cognitive/mental) [ ] Other:  |
| **Biological Mother’s Name**: | Birth Date | Current Employment: |
| Race/Ethnicity: | Legal custody (full/shared/none): |
| Street Address:  | City:  | State:  | Zip code:  |
| Primary phone:  | Secondary phone:  | Email:  |
| **Biological Father’s Name**: | Birth Date | Current Employment: |
| Race/Ethnicity: | Legal custody (full/shared/none): |
| Street Address:  | City:  | State:  | Zip code:  |
| Primary phone:  | Secondary phone:  | Email:  |
| **Primary Caregiver’s Name**: | Birth Date | Current Employment: |
| Relationship to child (grandparent, foster parent, etc).:  |  |
| Race/Ethnicity: | Legal custody (full/shared/none): |
| Street Address:  | City:  | State:  | Zip code:  |
| Primary phone:  | Secondary phone:  | Email:  |

|  |
| --- |
| **Brothers & Sisters** (include step- and half-siblings; if more space is needed, please write on the back of the form)  |
| Name | Age | Relationship to client (e.g., child, partner, friend, etc.) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Other Household Members**  |
| Name | Age | Relationship to client (e.g., child, partner, friend, etc.) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Worker’s Name** (i.e., DSS, DJS, etc.):  | Phone number:  |
| Worker’s Supervisor’s Name:  | Phone number:  |
| Street address:  | City: | State:  | Zip code:  |
| **Pediatrician/Practice Name:**  | Phone number:  |
| Street address:  | City:  | State:  | Zip code:  |
| **School Name:**  | Grade:  |
| Street address:  | City: | State: | Zip: |
| Teacher’s name: | Phone number? |

 |
|   |