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CENTER FOR ADOPTION SUPPORT AND EDUCATION
Maryland Contract Referral Form

Date: _____ Jurisdiction/County submitting referral: _____

REFERRED CHILD SECTION:

Child's Name: _____
Last First Name "Preferred Name"

Child's DOB: _____

Child's current status: (check one)	If in adoptive home/foster placement,
❑ In foster care/pre-adoption	Age at adoptive/foster placement: _____ (Years/Months)
❑ In adoptive placement; not finalized	
❑ In adoptive home; adoption finalized	Years/months in adoptive home/foster placement: _____ (Years/Months)

Type of Adoption		
❑ Public (child welfare)	Department of Social Services: (City/County/State) _____	
Special needs: ☐ yes ☐ no	Subsidy approved: ☐ yes ☐ no	
❑ Private ❑ Kinship ❑ International	Country of Origin _____	

Members of Household				
Name	Gender	DOB	Race*	
Father				
Mother				
Child-				
Siblings	Gender	DOB	Race*	Adopted? Yes/No
Others Residing in Home	Gender	DOB	Race*	Relationship

If more space is needed, please use the back of this sheet →

Thank you!

* Race/ethnicity codes: A= Asian; AA=African-American/Black; C=Caucasian/White; Hisp=Hispanic/Latin ethnicity; Multi=Multi-racial; NA=Native American/Alaskan; HI=Hawaiian/Pacific Islander

Prior Mental Health History: (Y) (N): if (Y) briefly describe: Dates/Providers/Hospitalizations

REFERRAL INFORMATION:

Referred by: _____
(First name, Last name, Department)

Email/Phone Number:

Reason for Referral: (**select one**)
□ Individual Therapy □ Family Therapy □Family Support Group

CAREGIVER SECTION:

Caregiver #1:
Last Name First Name

DOB: Caregiver #1

Caregiver #2:
Last Name First Name

DOB: Caregiver #2

Address:
Street Address City State Zip

Email:
(Caregiver #1) (Caregiver #2)

Preferred Method of Contact: Cell Phone/Landline (circle one) Provide below:

Contact:
(Caregiver #1) (Caregiver #2)

Briefly describe any background or pertinent information that will help us engage this family: