# Foster Care Support Clinic - Referral Form

Who will accompany the child to the FCSC Initial Appointment? **DSS or Foster Parent** (circle)

**Demographics**

Referral Date: _____ Child's Name: _____
DOB: _____ Age: _____ Sex: _____ Race: _____S.S. #: _____
Medicaid #: _____ Medicaid Type (Select Health, First choice, etc)_____
Foster Parent: _____ Home Phone: _____
Address: _____Cell Phone: _____
County: _____
DSS Caseworker:_____ Supervisor: _____
County: _____ Phone: _____ Fax:_____
Therapeutic Placement Agency _____
School: _____ *Regular or Special Ed* (circle)
Previous Primary Care Provider: _____
Other services involved: _____

**Social History**

Date of entry to Foster Care:_____
Reason for placement in DSS Custody: _____
DSS Permanency Plan:_____
Has the child been seen or referred to a Child Advocacy Center (DNLCC/DCC)? _____

**Medical History**

Referral Reason: **Establish Primary Care** **Consult for Behavioral Concerns** (circle one)
Concerns/Issues:_____
_____
Diagnosis:_____
Pertinent Past Medical
History:_____
_____
Allergies:_____
Medications:_____
_____
_____
Prescription refills needed at Foster Care Entry
_____

Notes: _____
_____
Referral Source: _____

**Please Fax all referral forms, immunization records, and past medical records prior to date of scheduled appointment to (843) 876-1935** *Updated 4/19/16*

| *Internal FCSC Use Only* | |
|---|---|
| ◯ Contact with FP/Date_____ | ◯ FP/DSS Declined Apt |
| ◯ Medicaid # needed | ◯ Unable to reach DSS/FP x3 attempts and referral closed |
| ◯ Immunization Requested/Attached | #1_____ #2 _____#3 _____ |