CFS 2033-1
Rev 1/2015

State of Illinois
Department of Children and Family Services

Illinois Choices Referral Form

Directions: This form should be completed for any ward that meets the criteria for referral to SOC or CIPP. The form must be completed electronically by the child's caseworker to begin the referral process. The completed form should be submitted via email to Choices.Referral@illinois.gov along with the completed Consent and Choices Authorization forms. If you have any problem submitting the referral form, please contact Angel Tipsword at 217-840-6049.

REFERRAL DATE (mm/dd/yyyy): COUNTY OF PLACEMENT:

HAS A 14 DAY NOTICE OF PLACEMENT CHANGE BEEN ISSUED? --PLEASE SELECT--

REASON FOR REFERRAL: --PLEASE SELECT--

PLEASE EXPLAIN:

PRIMARY CITY OF THE YOUTHS FAMILY SUPPORTS:

CITY OR REGION IN WHICH THE YOUTH WOULD PREFER TO RESIDE:

CASEWORKER INFORMATION

AGENCY: NAME:

ADDRESS (including City,State,Zip):

PHONE (xxx-xxx-xxxx): FAX: EMAIL:

SUPERVISOR NAME:

YOUTH INFORMATION

FIRST NAME: MI: LAST NAME: SUFFIX: --Optional--

DCFS ID: RIN#: DOB: GENDER: --REQUIRED--

ETHNICITY: --PLEASE SELECT-- RACE: --PLEASE SELECT--

PRIMARY LANGUAGE: --PLEASE SELECT-- EDUCATION: --PLEASE SELECT--

RELIGION: --PLEASE SELECT-- MARITAL STATUS: --PLEASE SELECT--

LEGAL STATUS: --REQUIRED--

Youth's Full Name:

CURRENT PLACEMENT INFORMATION

PLACEMENT DATE: PLACEMENT TYPE: --PLEASE SELECT--

IF PLACEMENT TYPE IS …	
CONGREGATE CARE (eg RTC, GROUP HOME, DETENTION, HOSPITAL) OR INDEPENDENT LIVING	FACILITY NAME: CONTACT NAME: ADDRESS LN 1: ADDRESS LN 2: CITY: STATE: --PLEASE SELECT-- ZIP: PHONE (xxx-xxx-xxxx):

IF PLACEMENT TYPE IS …	
FAMILY, FRIEND, OR RELATIVE'S HOME OR FOSTER CARE	CARETAKER FIRST NAME: CARETAKER LAST NAME: ADDRESS LN 1: ADDRESS LN 2: CITY: STATE: --PLEASE SELECT-- ZIP: PHONE (xxx-xxx-xxxx): COUNTY: RELATIONSHIP TO YOUTH: --PLEASE SELECT-- SUPPORT TYPE: --PLEASE SELECT--

CHILD WELFARE INVOLVEMENT

DATE OF FIRST CONTACT WITH CHILD WELFARE: # OF SUBSTANTIATED ALLEGATIONS:

CURRENT CHILD WELFARE INVOLVEMENT? --PLEASE SELECT--

CURRENT PERMANANCY PLAN: --PLEASE SELECT--

Youth's Full Name:

PLACEMENT HISTORY

DATE OF FIRST REMOVAL:

TOTAL # OF REMOVALS:

PLACEMENT TYPE	# OF PLACEMENTS	DATE OF FIRST
FOSTER CARE		
GROUP HOME		
RESIDENTIAL		
PSYCHIATRIC HOSPITAL		
DETENTION		

PLACEMENT HISTORY DETAILS:

JUVENILE JUSTICE (JJ) INVOLVEMENT

HAS THE YOUTH EVER BEEN INVOLVED IN THE JUVENILE JUSTICE SYSTEM? --PLEASE SELECT--

DATE OF FIRST JJ CONTACT: CURRENT JJ INVOLVEMENT? --PLEASE SELECT--

ARRESTS: # TRUE FINDINGS: SEVERITY OF MOST RECENT TRUE FINDING: --PLEASE SELECT--

Youth's Full Name:

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MENTAL HEALTH INFORMATION

ANY MENTAL HEALTH SERVICES? --PLEASE SELECT-- DATE OF FIRST CONTACT:

DOES THE YOUTH HAVE A DSM AXIS I OR II DIAGNOSIS? --PLEASE SELECT--

IF YES, PLEASE ANSWER THE FOLLOWING:

DATE OF DIAGNOSIS: ASSESSOR SOURCE:

AXIS I DX	AXIS II DX

HAS THE YOUTH BEEN PRESCRIBED MEDICATIONS? --PLEASE SELECT--

IF **YES**, PLEASE ANSWER THE FOLLOWING:

DO THE MEDICATIONS APPEAR EFFECTIVE? --PLEASE SELECT--

IS THE YOUTH CURRENTLY COMPLIANT WITH THE MEDICATIONS? --PLEASE SELECT--

	MEDICATION NAME	START DATE	DOSAGE	FREQUENCY
1.				
2.				
3.				
4.				
5.				
6.				

EDUCATION INFORMATION

CURRENT SCHOOL STATUS: --PLEASE SELECT--

NAME OF MOST RECENT SCHOOL ATTENDED:

EFFECTIVE DATE: SCHOOL TYPE: --PLEASE SELECT--

IS THERE AN IEP? --PLEASE SELECT--

IF YES, SPECIAL EDUCATION ELIGIBILITY: --PLEASE SELECT--

CCO OFFICE USE ONLY

DATE SUBMITTED TO CCO:

TIER: --PLEASE SELECT--

DATE REFERRING TO CHOICES:

Youth's Full Name: