CSF 531
Rev 05/2009

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

Directions: Enter all requested information and e-mail the completed form via Outlook to "nurseref" or fax to the attention of the Child Welfare Associate Specialist at 866-531-1459. Incomplete and handwritten referrals will not be processed.

CASE INDENTIFICATION INFORMATION

CHILD'S NAME:	☐ Male ☐ Female
PARENT'S NAME:	CHILD'S DATE OF BIRTH:
Address:	Home Telephone:
	Work Telephone:
	CYCIS ID:
Legal Status of Child: Date:	SACWIS ID:
Family's Primary Language:	SCR#:

Complete the following section if the child has a substitute caregiver.

Caregiver's Name:	Work Telephone:
Caregiver's Relationship to Child:	Home Telephone:
Caregiver's Address:	Cell Telephone:

REFERRAL INFORMATION

Worker's Name:	Telephone:
Address:	Fax Number:
	R/S/F:
Supervisor's Name:	Telephone:
☐ DCFS ☐ POS-Agency Name:	

CSF 531
Rev 05/2009

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

Complete the following section if the person making the referral is different than the assigned caseworker.

Name:	Telephone:
Address:	Fax Number:
☐ DCFS ☐ POS ☐ DCP ☐ HealthWorks ☐ Regional Nurse ☐ DSCC	

CHILD SPECIFIC INFORMATION

Child's Primary Care Physician:	Telephone:
Address:	Fax Number:

REASONS FOR REFERRAL (CHECK ALL THAT APPLY)

☐ **Emergency**	☐ Special Health Care Needs	☐ Psychiatric Diagnosis / Medication Regimen
☐ Consultation	☐ Medication Information	☐ Discharge Assessment (Hospital)
☐ Notification Only	☐ Medical Record Review	☐ Health Care Plan Guidance
☐ Home Assessment	☐ Physician Contact	☐ Health Resource Needed
☐ Site Visit – Location of Visit:		
☐ Staffing/CAYIT – Date, Time & Location:		
☐ Casual Inquiry – Information Needed:		

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

☐ Medical Information Needed – Specify if Known:

PROBLEM(S)/DIAGNOSIS(ES):

☐ Child Hospitalized – Hospital Name, Address, Contact Person's Name and Telephone:

CSF 531
Rev 05/2009

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

ATTACHED DOCUMENTATION

☐ Diagnosis
☐ Current Treatment Plan
☐ Individual Education Plan
☐ Hospital Discharge Summary
☐ Psychological/Psychiatric Reports
☐ System of Care or Specialized Designation
☐ Current Progress Reports/ Treatment Summary
☐ Statement of services that are in process of being implemented
☐ Medical Unusual Incident Reports
☐ Other – Specify:

_____

Signature and Date of Referring Worker

CSF 531
Rev 05/2009

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

NURSE'S INFORMATION

Date Referral Received:	Assigned To:
Date Referral Received by DCFS Nurse:	Time

☐ **Referral Accepted** ☐ **Referral NOT Accepted**

Using the Nursing Process document your initial nursing assessment; NANDA Nursing Diagnosis; interventions, evaluations/recommendations, and plans for the services required by a child with special health care needs **OR**; Document your reasons(s) for NOT accepting the referral using the Nursing Process for your initial nursing assessment and applicable NANDA Nursing Diagnosis.

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

CSF 531
Rev 05/2009

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

CSF 531
Rev 05/2009

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

CSF 531
Rev 05/2009

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

CSF 531
Rev 05/2009

State of Illinois
Department of Children and Family Services

DCFS Regional Nurse Referral Form

CHILD'S NAME:_____ DATE OF BIRTH:_____

Nurse's Signature, Date and Region