CFS 440-6
Rev 9/99

# Department of Children and Family Services
## DCFS Referral for Adult Alcohol and Other Drug Treatment Services
**(to be completed by DCFS/POS worker)**

| | |
|---|---|
| Name of Referral: | Date of Birth: |
| Address: | Phone: |
| Marital Status: | DCFS Case #: |

| Adults Living in the Household | Relationship to Client |
|---|---|
| 1) | |
| 2) | |
| 3) | |
| 4) | |
| 5) | |
| 6) | |

| Children | Age | Sex | Placement Information |
|---|---|---|---|
| 1) | | | |
| 2) | | | |
| 3) | | | |
| 4) | | | |
| 5) | | | |
| 6) | | | |

| | |
|---|---|
| Child Welfare Worker's Name (print): | Worker's Phone: |
| Worker's Signature | Date of Referral: |
| Supervisor's Name (print): | Supervisor's Phone: |
| DCFS Office or POS Agency Name: | |

Attach copies of: Adult Substance Abuse Screen (CFS 440-5)
Consent for Disclosure (CFS 440-7)