NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

State of New Jersey
Department of Children and Families
Division of Child Protection and Permanency
(DCP&P)

# DCP&P Referral for Regional Diagnostic & Treatment Center Services

TO: Choose RDTC

FROM:

| | |
|---|---|
| CP&P Caseworker: | Office Phone:<br>Mobile Phone:<br>Email Address: |
| CP&P Supervisor: | Phone:<br>Email Address: |
| Referral Gatekeeper: | Phone:<br>Email Address: |
| Local Office: | Address:<br>Fax: |

DATE OF REFERRAL TO RDTC:

**CASE INFORMATION**

CASE NAME:

NJ SPIRIT CASE ID #:

**SERVICE(s) REQUESTED:**

- ☐ Child Abuse & Neglect Medical Exam
- ☐ Child Abuse & Neglect Psychological Evaluation
- ☐ Medical Record Review
- ☐ Therapy / Counseling
- ☐ Child Psychiatric Evaluation (CARES ONLY)

**PLEASE FIND THE ATTACHED DOCUMENTS:**

*(provide all available & applicable documents and check all that apply; please note each Center will have their own HIPAA and consent forms)*

- ☐ CP&P Screening Summaries
- ☐ CP&P Investigation Summaries
- ☐ CP&P Family Risk Assessment
- ☐ CP&P Safety Plan
- ☐ Court Order (if services is court-ordered)
- ☐ Police Reports
- ☐ SAR
- ☐ Previous Evaluations
  - ☐ Psychological / Psychiatric
  - ☐ Child Study Team
- ☐ CP&P Litigation Complaint
- ☐ CP&P Family Case Plan / Family Agreement
- ☐ Photos
- ☐ Medical Records
  - ☐ Primary Care Provider
  - ☐ Hospital / ER
  - ☐ Birth
  - ☐ Medical Examiner
- ☐ Other:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

CASE NAME: NJS CASE ID #: DATE OF REFFERAL:

**FAMILY MEMBER(s) REFERRED FOR SERVICES:**

*PERSON 1*

NAME:

DATE OF BIRTH: GENDER IDENTITY:

PARTICIPANT NJS ID: RELATED CASES:

CONTACT INFO / PHONE #:

SERVICE REQUESTED: Choose an item

INTERPRETER NEEDED FOR ANY FAMILY MEMBER? ☐ Yes ☐ No

IDENTIFY LANGUAGE/PERSON:

IS THE CHILD/YOUTH COVERED BY, OR ELIGIBLE FOR, HEALTH INSURANCE? ☐ Yes ☐ No ☐ Unknown

MEDICAID #: OTHER INSURANCE:

PARENT/CAREGIVER 1 NAME:

PARENT/CAREGIVER 1 PHONE: EMAIL:

PARENT/CAREGIVER 2 NAME:

PARENT/CAREGIVER 2 PHONE: EMAIL:

WITH WHOM DOES THE CHILD/YOUTH RESIDE? ☐ CAREGIVER 1 ☐ CAREGIVER 2 ☐ BOTH

**ALLEGATIONS**

☐ Physical Abuse SPECIFY TYPE:

☐ Emotional Abuse ☐ Sexual Abuse ☐ Neglect

**FINDINGS:**

☐ Substantiated ☐ Established ☐ Not Established ☐ Unfounded ☐ Pending

ALLEGED PERPETRATOR & AGE:

RELATIONSHIP TO CHILD / YOUTH:

DATES OF ALLEGED ABUSE: DATE OF DISCLOSURE:

DOES ALLEGED PERPETRATOR HAVE CONTACT WITH THE ALLEGED VICTIM ☐ Yes ☐ No ☐ Unknown

LAST KNOWN DATE OF CONTACT:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

CASE NAME: NJS CASE ID #: DATE OF REFFERAL:

**FAMILY MEMBER(s) REFERRED FOR SERVICES:**

*PERSON 2*

NAME:

DATE OF BIRTH: GENDER IDENTITY:

PARTICIPANT NJS ID: RELATED CASES:

CONTACT INFO / PHONE #:

SERVICE REQUESTED: Choose an item

INTERPRETER NEEDED FOR ANY FAMILY MEMBER? ☐ Yes ☐ No

IDENTIFY LANGUAGE/PERSON:

IS THE CHILD/YOUTH COVERED BY, OR ELIGIBLE FOR, HEALTH INSURANCE? ☐ Yes ☐ No ☐ Unknown

MEDICAID #: OTHER INSURANCE:

PARENT/CAREGIVER 1 NAME:

PARENT/CAREGIVER 1 PHONE: EMAIL:

PARENT/CAREGIVER 2 NAME:

PARENT/CAREGIVER 2 PHONE: EMAIL:

WITH WHOM DOES THE CHILD/YOUTH RESIDE? ☐ CAREGIVER 1 ☐ CAREGIVER 2 ☐ BOTH

**ALLEGATIONS**

☐ Physical Abuse SPECIFY TYPE:

☐ Emotional Abuse ☐ Sexual Abuse ☐ Neglect

**FINDINGS:**

☐ Substantiated ☐ Established ☐ Not Established ☐ Unfounded ☐ Pending

ALLEGED PERPETRATOR & AGE:

RELATIONSHIP TO CHILD / YOUTH:

DATES OF ALLEGED ABUSE: DATE OF DISCLOSURE:

DOES ALLEGED PERPETRATOR HAVE CONTACT WITH THE ALLEGED VICTIM ☐ Yes ☐ No ☐ Unknown

LAST KNOWN DATE OF CONTACT:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

CASE NAME: NJS CASE ID #: DATE OF REFFERAL:

**FAMILY MEMBER(s) REFERRED FOR SERVICES:**

*PERSON 3*

NAME:

DATE OF BIRTH: GENDER IDENTITY:

PARTICIPANT NJS ID: RELATED CASES:

CONTACT INFO / PHONE #:

SERVICE REQUESTED: Choose an item

INTERPRETER NEEDED FOR ANY FAMILY MEMBER? ☐ Yes ☐ No

IDENTIFY LANGUAGE/PERSON:

IS THE CHILD/YOUTH COVERED BY, OR ELIGIBLE FOR, HEALTH INSURANCE? ☐ Yes ☐ No ☐ Unknown

MEDICAID #: OTHER INSURANCE:

PARENT/CAREGIVER 1 NAME:

PARENT/CAREGIVER 1 PHONE: EMAIL:

PARENT/CAREGIVER 2 NAME:

PARENT/CAREGIVER 2 PHONE: EMAIL:

WITH WHOM DOES THE CHILD/YOUTH RESIDE? ☐ CAREGIVER 1 ☐ CAREGIVER 2 ☐ BOTH

**ALLEGATIONS**

☐ Physical Abuse SPECIFY TYPE:

☐ Emotional Abuse ☐ Sexual Abuse ☐ Neglect

**FINDINGS:**

☐ Substantiated ☐ Established ☐ Not Established ☐ Unfounded ☐ Pending

ALLEGED PERPETRATOR & AGE:

RELATIONSHIP TO CHILD / YOUTH:

DATES OF ALLEGED ABUSE: DATE OF DISCLOSURE:

DOES ALLEGED PERPETRATOR HAVE CONTACT WITH THE ALLEGED VICTIM ☐ Yes ☐ No ☐ Unknown

LAST KNOWN DATE OF CONTACT:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

**PLACEMENT, CUSTODY, AND GUARDIANSHIP:**

☐ In-Home (custody remains with legal guardians)

☐ Out of Home (CP&P has care, custody, and supervision)

DATE OF ENTRY INTO OUT OF HOME CARE:

OUT OF HOME PLACEMENT TYPE:

☐ Kinship ☐ Unrelated Resource ☐ Residential ☐ Other:

**CHILD'S/YOUTH'S CURRENT PRIMARY CAREGIVER(s):**

RELATIONSHIP TO CHILD:

NAME:

ADDRESS & ZIP CODE:

PHONE #:

**CHILD'S/YOUTH'S LEGAL GUARDIAN** (If different from above):

NAME:

ADDRESS & ZIP CODE:

PHONE #:

IS CP&P INVOLVED IN LITIGATION WITH THIS FAMILY? ☐ Yes ☐ No

HAVE PARENTAL RIGHTS BEEN TERMINATED AND DCP&P HAS LEGAL GUARDIANSHIP?

☐ Yes (mother) ☐ Yes (father) ☐ Yes (both) ☐ No

**ADDITIONAL COMMENTS / NOTES:**

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

**REASON FOR REFERRAL AND SPECIFIC QUESTIONS:**

1. Describe the current allegations and situation:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

**REASON FOR REFERRAL AND SPECIFIC QUESTIONS:**

2. Describe any statements, disclosures, or behaviors made/exhibited by the child related to the current allegation. Identify if alleged child victim was interviewed, by whom, and when:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

**REASON FOR REFERRAL AND SPECIFIC QUESTIONS:**

3. Describe the purpose of the service requested:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

**REASON FOR REFERRAL AND SPECIFIC QUESTIONS:**

4. Provide case-specific referral questions for the Provider to answer and identify what CP&P seeks to learn from the requested service:
   a.

   b.

   c.

   d.

Are there any barriers/safety concerns preventing family members from attending evaluation together?

☐ Yes ☐ No

Do any family members have a history of violent behavior towards others?

☐ Yes ☐ No

If Yes to either question, please explain below:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

**PREVIOUS CP&P HISTORY:** (attach additional sheets as necessary)

1. Summarize previous CP&P involvement:

2. Summarize previous, related medical and mental/behavioral health evaluations:

## DCP&P Referral for Regional Diagnostic & Treatment Center Services

**PREVIOUS CP&P HISTORY:** (attach additional sheets as necessary)

3. Describe previous and/or current utilization of mental health service:

4. Does the referred have a previous and/or current psychological and/or psychiatric diagnosis?
   ☐ Yes ☐ No
   a. Current Diagnosis:
   b. Current Medications:
   c. Previous Diagnosis:
   d. Previous Medications:

Please contact the caseworker or supervisor with any questions or comments. Thank you.

Caseworker Signature _____ Date _____

Supervisor Signature _____ Date _____

Gatekeeper Signature _____ Date _____