

Hello,

Thank you for your referral to the Foster Care Clinic. Prior to the evaluation, the clinic reviews past medical, mental health and legal records of the child. We request the following documents for the evaluation: CFEs (including initial CFE), order of dependency, dependency review, CHET, medical records including birth records, primary care, urgent care/ED visits, medical specialty consults, mental health records, school records (504plans or IEPs, require the IEP with most recent neurocognitive testing), signed psychological referral form per CA contract (attached to the email or available on website). The nurse coordinator will work with case worker and family to complete documentation collection. Once the record collection is complete, we will schedule the appointment for the evaluation.

Documents can be faxed to ATTN FOSTER CARE 206-744-8529 or securely emailed to [hmcfcc@uw.edu](mailto:hmcfcc@uw.edu) (encrypted) or through the Washington State secure portal. Email is the preferred route. Below are the questions for the intake, which can be filled out in the table and emailed to [hmcfcc@uw.edu](mailto:hmcfcc@uw.edu) or call the nurse coordinator to discuss over the phone.

Three weeks after the initial evaluation, the psychologist will have a follow up appointment via phone call, with the caregiver(s), DSHS case worker and Apple Health Care Coordinator to discuss recommendations. A copy of the report will also be sent out to the primary care provider.

We look forward to working with you to serve this child.

Sincerely,

**Harborview Foster Care Clinic Team**

Email: [hmcfcc@uw.edu](mailto:hmcfcc@uw.edu)

Phone: 206-744-4737

Fax: 206-744-8529 ATTN Foster Care Clinic

Address: 325 Ninth Avenue Box 359850

Seattle, WA 98104

Website: [www.hmcfostercarewa.org](http://www.hmcfostercarewa.org)

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| **HMC Foster Care Clinic Referral** | |
| **Patient’s full name**  **DOB**  **Gender**  **Race/ethnicity**  **Provider One #**  **Social Security Number** |  |
| **Reason for Referral?** |  |
| **What is the goal of the referral?**  **(Diagnosis clarification, treatment recommendations, behavioral management support/consultation, medication needs, help to obtain referral i.e. FAS clinic)** |  |
| **Foster parent(s)/Caregiver name(s)**  **Address**  **Phone**  **Email** |  |
| **DSHS Case Worker**  **Address**  **Phone**  **Email** |  |
| **Other advocates or involved members of patient’s care**  **Name, Phone, and Email** |  |
| **Current School and Grade**  **Current Teacher(s) Names and email address?**  **Recent schools**  **IEP or 504 plan?**  **Issues with school performance?** |  |
| **Current Mental Health Agency and Provider Name(s)**  **Phone/Fax?**  **Start date, frequency, name of therapist, type of therapy** |  |
| **Prior Mental Health Care**  **Please list all places patient has received consults or mental health care, include therapist name and type of therapy if available.** |  |
| **Current AND prior psych diagnoses** | Current:  Past: |
| **Type of placement (Kinship, transitional, foster adopt, group)** |  |
| **Date of initial placement** |  |
| **Begin date of current placement** |  |
| **Total number of placements** |  |
| **Plan (Reunification, concurrent planning?) Parent rights terminated? Date?** |  |
| **Number of siblings**  **Current contact with siblings** |  |
| **Current contact with biological parents** |  |
| **Reason for removal and placement history** |  |
| **Who currently lives with patient in foster home?** |  |
| **Birth hospital name and location Mother’s Name and DOB**  *(please request birth records now if not already on file)* |  |
| **Medical history, medical diagnoses** |  |
| **Surgical history** |  |
| **PCP Name and Clinic Name/Phone & Fax Numbers**  **Last Well Child Appt?**  **Last Dental Appt?**  **Last Vision Appt?** |  |
| **Other medical facilities child has received care from? (i.e. consults, urgent cares, dental care, emergency department, occupational, speech or physical therapy)** |  |
| **Food or drug allergies?** |  |
| **Family Medical History** |  |
| **Family Psychological History** |  |
| **Current Medications**  **Prior psychiatric medications used** | Current:  Past: |
| **Current concerns, pertinent history, active issues** | |