Connecticut Department of Children and Families

MEDICAL REVIEW BOARD REFERRAL

DCF-785

LEGAL (Rev. 9/9/20)

TO: Chairperson, Medical Review Board			
FROM: SW LAST Name:	SW FIRST Name:	SW E-mail:	Phone:
Date:	DCF Office: Select DCF Office		

CHILD / PLACEMENT INFORMATION

Child LAST Name	Child FIRST Name	DOB:	Gender: Please Select (or enter your own)	
Child Race: Please Select One	Child Ethnicity: Please Select One	Date of Referral:	Case ID#:	Person ID #:

Placement Date:	Child's Legal Status: Please Select One	Child's Religion, if any: Please Select One	What is the permanency plan?: Please Select One

Current Placement: ☐ Foster Home ☐ Adoptive Home ☐ Residential ☐ Hospital: ☐ Other:

Name of Placement:			Placement E-Mail:	Placement Phone:
Address (No. and Street)	Apt. #/Suite:	City:	State:	Zip:
Name of Primary Health Provider (Local Physician):			Provider E-Mail:	Phone:
Name of Sub-Specialist/Clinic:			Specialist E-Mail:	Phone:

REASON FOR MEDICAL REVIEW BOARD REFERRAL

Is child hospitalized currently? ☐ Yes ☐ No

Description of the circumstances requiring MRB review:

Action requested:

List Current Medication(s) and dosages, if any:	List Allergies, if any:

☐ Current placement is/are aware of the post-op requirements and can properly care for the child upon return to the placement.

☐ Current placement CANNOT fully care for the child upon return, please specify what alternative arrangements have been developed:

NOTIFICATIONS AND COMMUNICATION:

Check all that apply and attach documentation of all contacts. Documentation must indicate whether each individual understands why the procedure is necessary, understands the risks and benefits and agrees with the recommendation. If the individual is not in agreement, document reason for disagreement.

Child

☐ understands and is aware of the surgery or medical plan including the procedure, its risks and benefits **AND**

☐ is in agreement with the plan **OR**
☐ does NOT agree and/or does not understand. Please explain:

Child's Attorney:

☐ is aware of the surgery or medical plan including the procedure, its risks and benefits **AND**

☐ is in agreement with the plan **OR**
☐ is **NOT** in agreement with the plan. Please attach documented reason(s) for disagreement.

Childs Attorney LAST Name:	Childs Attorney FIRST Name:	Attorney's E-mail:	Child's Attorney's Phone:

Child's GAL (If applicable):

☐ is aware of the surgery or medical plan including the procedure, its risks and benefits **AND**

☐ is in agreement with the plan **OR**
☐ is **NOT** in agreement with the plan. Please attach documented reason(s) for disagreement.

Childs GAL LAST Name:	Childs GAL FIRST Name:	GAL E-mail:	GAL Phone:

NOTIFICATIONS AND COMMUNICATION (*Continued*):

Mother / Parent #1:

☐ **Department has made attempts to contact mother and has been unable to do so (Explain)**

☐ understands and is aware of the surgery or medical plan including the procedure, its risks and benefits **AND**

☐ is in agreement with the plan **OR**
☐ is **NOT** in agreement with the plan. Please attach documented reason(s) for disagreement.

Mother's/P#1 LAST Name:	Mother's/P#1 FIRST Name:	Mother's/P#1 E-mail:	Mother's/P#1 Phone:

Mother's / Parent #1 ATTORNEY:

☐ is aware of the surgery or medical plan including the procedure, its risks and benefits **AND**

☐ is in agreement with the plan **OR**
☐ is **NOT** in agreement with the plan. Please attach documented reason(s) for disagreement.

Mother's Attorney LAST Name:	Mother's Attorney FIRST Name:	Attorney's E-mail:	Mother's Attorney's Phone:

Father / Parent #2

☐ **Department has made attempts to contact father and has been unable to do so (Explain)**

☐ understands and is aware of the surgery or medical plan including the procedure, its risks and benefits **AND**

☐ is in agreement with the plan **OR**
☐ is **NOT** in agreement with the plan. Please attach documented reason(s) for disagreement.

Father's/P#2 LAST Name:	Father's/P#2 FIRST Name:	Father's/P#2 E-mail:	Father's/P#2 Phone:

Father's / Parent #2 ATTORNEY:

☐ is aware of the surgery or medical plan including the procedure, its risks and benefits **AND**

☐ is in agreement with the plan **OR**
☐ is **NOT** in agreement with the plan. Please attach documented reason(s) for disagreement.

Father's/P#2 Attorney LAST Name:	Father's/P#2 Attorney FIRST Name:	Father's/P#2 Attorney's E-mail:	Father's Attorney's Phone:

Foster Parent(s):

☐ is/are aware of the surgery or medical plan including the procedure, its risks and benefits **AND**

☐ is in agreement with the plan **OR**
☐ is **NOT** in agreement with the plan. Please attach documented reason(s) for disagreement.

Foster Parent #1LAST Name:	Foster Parent #1 FIRST Name:	Foster Parent #1 E-mail:	Foster Parent's Phone:
Foster Parent #2 LAST Name:	Foster Parent #2 FIRST Name:	Foster Parent #2 E-mail:	Foster Parent's Phone:

☐ **Primary Care Provider** is aware of the surgery or medical plan and in agreement with the plan.

☐ **Specialty Provider(s)** is/are aware of the surgery or medical plan and in agreement with the plan.

☐ **Office Director** is aware of the plan and the results of all notifications and is in agreement with the plan.

AUTHORIZATION AND SIGNATURES

SW LAST Name:	SW FIRST Name:	Signature:	Phone:	Date:
RRG Nurse LAST Name:	RRG Nurse FIRST Name:	Signature:	Phone:	Date:
SWS LAST Name:	SWS FIRST Name:	Signature:	Phone:	Date:
PS LAST Name:	PS FIRST Name:	Signature:	Phone:	Date:
OD LAST Name:	OD FIRST Name:	Signature:	Phone:	Date: