Connecticut Department of Children and Families MEDICAL REVIEW BOARD REFERRAL

DCF-785 LEGAL (Rev. 9/9/20)



TO: Chairperson, Medical Review Board									
10: Chairperson,	pard					1			
FROM: SW LAST Name:		SW FIRST Name:			SW E-mail:			Phone:	
Date:		DCF Office:							
				PLAC	CEMENT	NFORMA	TION		
Child LAST Name		Child FIRST N	Name			DOB:	Gender:		
Child Race:		Child Ethnicity	y:			Date of Re	eferral:	Case ID#:	Person ID #:
Placement Date:	Child's Legal Status	:		Child	d's Religion	, if any:		What is the permanency plan?:	
Current Placement:	☐ Foster Home	☐ Adoptive	Home	☐ Re	esidential	☐ Hospi	tal: 🔲 Otl	ner:	
Name of Placement:						<u> </u>	Placement	F-Mail:	Placement Phone:
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Address (No. and Stre	et)		Apt. #/Sı	uite.	City:			State:	Zip:
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Name of Primary Hea	Ith Provider (Local Ph	veician).					Provider E-	⊥ Mail·	Phone:
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Name of Sub-Special	iet/Clinic:						Coorielist E	: Mail:	Phone:
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Page 2 of 3 DCF-785 Medical Review Board Referral Action requested:

List Allergies, if any: List Allergies, if any:				
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DCF-785 Medical Review Board Referral Page **3** of **3**

NOTIFICATIONS AND COMMUNICATION (Continued):								
Mother / Parent #1: ☐ Department has made attempts t	o contact mother and has been unabl	e to do so (Explain)						
understands and is aware of the sur	gery or medical plan including the proce	dure, its risks and benefits AND						
is in agreement with the plan								
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:								
	plan including the procedure, its risks and	d benefits AND						
is in agreement with the plan of is NOT in agreement with the	OR plan. Please attach documented reasor	n(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								
\	o contact father and has been unable	to do so (Explain)						
understands and is aware of the sur	gery or medical plan including the proce	dure, its risks and benefits AND						
is in agreement with the plan								
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:								
	plan including the procedure, its risks and	d benefits AND						
is in agreement with the plan is NOT in agreement with the	OR plan. Please attach documented reasor	n(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):								
· · ·	cal plan including the procedure, its risks	s and benefits AND						
is in agreement with the plan is NOT in agreement with the	OR plan. Please attach documented reasor	n(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	e of the surgery or medical plan and in ag	greement with the plan.		ı				
☐ Specialty Provider(s) is/are awa	are of the surgery or medical plan and in	agreement with the plan.						
☐ Office Director is aware of the pl	an and the results of all notifications and	I is in agreement with the plan.						
		AND SIGNATURES						
SW LAST Name:	SW FIRST Name:	Signature:	Phone:		Date:			
RRG Nurse LAST Name:	RRG Nurse FIRST Name:	Signature:	Phone:		Data:			
RRG Nuise LAST Name.	RRG Nuise FIRST Name.	Signature.	Phone.	Phone: Date:				
SWS LAST Name:	SWS FIRST Name:	Signature: Pho			Date:			
PS LAST Name:	Name: PS FIRST Name:		Signature: Phone:		Date:			
OD LAST Name:	OD FIRST Name:	Signature:	Phone:		Date:			