

**MEDICAL REVIEW BOARD REFERRAL**

DCF-785

6/2026 (Rev.)

<b>TO: Chairperson, Medical Review Board</b>				
FROM: SW LAST Name:		SW FIRST Name:		SW E-mail:
				Phone:
Date:		DCF Office:		
<b>CHILD / PLACEMENT INFORMATION</b>				
Child LAST Name:		Child FIRST Name:		DOB:
				Gender:
Child Race:		Child Ethnicity:		Date of Referral:
				Case ID#:
				Person ID #:
Placement Date:	Child's Legal Status:		Child's Religion, if any:	
			What is the permanency plan?:	
Current Placement: <input type="checkbox"/> Foster Home <input type="checkbox"/> Adoptive Home <input type="checkbox"/> Residential <input type="checkbox"/> Hospital: <input type="checkbox"/> 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:	
<b>REASON FOR MEDICAL REVIEW BOARD REFERRAL</b>				
Is child currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Reason for MRB request and brief description of recommended treatment/procedure.				

**MEDICAL REVIEW BOARD REFERRAL**

List Current Medication(s) and dosages, if any:	List Allergies, if any:
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- Current placement is/are aware of the post treatment/procedure 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 treatment/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 treatment/procedure, risks and benefits **AND**

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

**Child's Attorney:**

is aware of the treatment/procedure, 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.
- Other Please explain:

Child's Attorney LAST Name:	Child's Attorney FIRST Name:	Child's Attorney's E-mail:	Child's Attorney's Phone:
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**Child's GAL (If applicable):**

is aware of the treatment/procedure, 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.
- Other Please explain:

Child's GAL LAST Name:	Child's GAL FIRST Name:	Child's GAL E-mail:	Child's GAL Phone:
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**Mother / Parent #1:**

Department has made attempts to contact mother and has **NOT** been able to do so (Explain)

understands and is aware of the treatment/procedure, 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.
- Other, Please explain:

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

is aware of the treatment/procedure, risks and benefits.

Mother's/P#1 Attorney LAST Name:	Mother's/P#1 Attorney FIRST Name:	Attorney's/P#1 E-mail:	Mother's/P#1 Attorney's Phone:
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**NOTIFICATIONS AND COMMUNICATION (Continued)**

**Father / Parent #2**

Department has made attempts to contact father and has **NOT** been able to do so (Explain)

understands and is aware of the treatment/procedure, 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.  
 Other, Please explain:

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

is aware of the treatment/procedure, risks and benefits.

Father's/P#2 Attorney LAST Name:	Father's/P#2 Attorney FIRST Name:	Father's/P#2 Attorney's E-mail:	Father's/P#2 Attorney's Phone:
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**Foster Parent(s)/Current Placement:**

is/are aware the treatment/procedure, 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.  
 Other. Please explain:

FP #1 LAST Name:	FP#1 FIRST Name:	FP#1 E-mail:	FP #1 Phone:
FP #2 LAST Name:	FP#2 FIRST Name:	FP#2 E-mail:	FP #2 Phone:

**Primary Care Provider** is aware of the treatment/procedure and is in agreement with the plan.  
 **Specialty Provider(s)** is/are aware of the treatment/procedure and is in agreement with the plan.  
 **Office Director** is aware of the treatment/procedure 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: