



FOSTER & ADOPTIVE CARE COALITION

FOR EVERY CHILD... A PLACE TO CALL HOME

Extreme Recruitment® Referral

Case Information

Child's Name:	DOB:
Child's Name:	DOB:
Child's Name:	DOB:
Child's Name:	DOB:
Child's Name:	DOB:
Date of Protective Custody:	Case plan:
County of Jurisdiction:	Case Management Agency:
Has TPR been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a court order allowing media recruitment in place? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, is team willing to pursue TPR? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, is team willing to obtain one prior to Extreme Recruitment®? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical and Mental Health Diagnoses of child(ren) being referred:	
Has there been a previous adoption finalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Team Member's Name

Contact Information

Case Manager:	
Case Management Supervisor:	
Juvenile Officer:	
Guardian ad Litem:	
Placement Provider:	
CASA:	
Other:	
Other:	

Referral Date:	Name of Person Making Referral:
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1750 S. Brentwood Blvd., Suite 210
St. Louis, Missouri 63144

t 800.FOSTER.3
o 314.367.8373

w www.foster-adopt.org
f 314.241.0715

