

CFS 2016  
4/2003

State of Illinois  
Department of Children and Family Services

CFS: \_\_\_\_\_

Child Name: \_\_\_\_\_

### CHILD CLINICAL SUMMARY

Child Id#: \_\_\_\_\_

R/S/F: \_\_\_\_\_

Date of Presentation: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Language: \_\_\_\_\_

Permanency Goal: \_\_\_\_\_

TPR:  Yes  No

Sexual Behavior Problems:  Yes  No

Family Involvement (include parent and sibling visitation): \_\_\_\_\_

Current Placement: \_\_\_\_\_

Length of Stay: \_\_\_\_\_

Most Current IQ: \_\_\_\_\_

Anticipated Discharge Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication(s): \_\_\_\_\_

Youth's strengths, interests and or hobbies (must list at least three): \_\_\_\_\_

Educational Summary (grade, type of programming- IEP or 504 plan, needs): \_\_\_\_\_

Emotional/Behavioral Needs: \_\_\_\_\_

Service Needs Upon Discharge: \_\_\_\_\_

Medical Needs: \_\_\_\_\_

Caseworker name: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_