 DFCS Referral

  Probation Referral

 Medical Referral

 Child  Adult **REFERRAL FORM Appt.: Date/Time: \_\_\_\_\_\_\_\_\_**

**Date:** \_\_\_\_\_\_\_\_\_ **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_ **Gender:** \_\_\_\_\_

**SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sponsor’s I.D. #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sponsor’s Full Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sponsor’s DOB:** \_\_\_\_\_\_\_\_\_\_ **Sponsor’s SS#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sponsor’s Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Grade**: \_\_\_\_\_\_\_\_\_\_ **EMP**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **EN**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status:** \_\_\_\_\_\_ **#of Children**: \_\_\_\_\_\_\_\_\_\_

**Name of Parent(s): Mother**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Father**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you the parent or legal guardian?** \_\_\_ **Yes** **Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_ **No**  **Legal Guardian’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Telephone: Home**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason For Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­

**Referral Source:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you receiving SSI Disability?** \_\_\_ **Yes**  \_\_\_ **No** **OR are you applying for SSI Disability?** \_\_\_ **Yes** \_\_\_ **No**

**Is it mental Disability?** \_\_\_ **Yes** \_\_\_ **No** **OR medical Disability** \_\_\_ **Yes** \_\_\_ **No**

**Have you been to another facility for mental health this year?** \_\_ **Yes** \_\_ **No Name Facility**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Services Requested:** \_\_\_\_ **Therapy( I, F, C, etc.)** \_\_\_\_ **FVIP Class** \_\_\_\_ **DUI School**

 **\_\_\_\_ Alcohol/ Drug Assessment \_\_\_\_ Anger Management**

 **\_\_\_\_ Alcohol/ Drug Class \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Pertinent Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 **Secretary/ Referral Person Signature Date**

Revised September 19, 2017