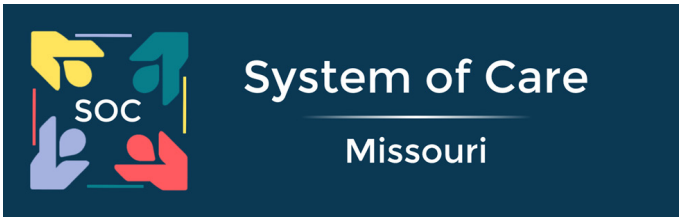


# Referral Form

## Referral Agency

| Agency | Agency Worker | Date of Referral |
|---|---|---|
| Agency Phone Number | Agency Fax | Agency Worker Email |

## Client Information

| First Name | Middle Name | Last Name | Suffix |
|---|---|---|---|
| SSN | Birthdate | Age | ☐ Male ☐ Female |

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Biracial ☐ Black/African American

☐ Native Hawaiian or Pacific Islander ☐ White/Caucasian ☐ Other

| School Name | Grade | Teacher's Name |
|---|---|---|

| Special Education Services (If yes, provide details) ☐ Yes ☐ No | IQ | Reading Level |
|---|---|---|

Axis I Diagnosis (if applicable)

Psychiatric History of Client

## Parent/Guardian Information

| Relationship to Child | Full Name of Parent or Guardian | Court Ordered? ☐ Yes ☐ No |
|---|---|---|

Address

| Home Phone | Cell Phone | Work Phone | Annual Income |
|---|---|---|---|

Household Members and Relation to Client

Drug or Alcohol Use by any household member (if yes, please provide details)

☐ Yes ☐ No

## Family Information

Reason for Referral of Family

| | | | |
|---|---|---|---|
| Family Information | Family Strengths | | |
| | Family Needs | | |
| | Barriers Faced by Family to Treatement Services | | |
| Other Agencies **Currently** Providing Services | Agency Name/Service | Contact Name and Phone | Who Receives Services |
| | Agency Name/Service | Contact Name and Phone | Who Receives Services |
| | Agency Name/Service | Contact Name and Phone | Who Receives Services |
| | Agency Name/Service | Contact Name and Phone | Who Receives Services |
| | Agency Name/Service | Contact Name and Phone | Who Receives Services |
| | Agency Name/Service | Contact Name and Phone | Who Receives Services |
| Other Agencies **with Past Involvement** | Agency Name/Services Provided | Contact Name and Phone | Who Received Services |
| | Agency Name/Services Provided | Contact Name and Phone | Who Received Services |
| | Agency Name/Services Provided | Contact Name and Phone | Who Received Services |
| | Agency Name/Services Provided | Contact Name and Phone | Who Received Services |
| | Agency Name/Services Provided | Contact Name and Phone | Who Received Services |
| | Agency Name/Services Provided | Contact Name and Phone | Who Received Services |

*As the Parent/Guardian of _____ , I give permission for the _____ System of Care team to discuss my child/family's current situation for treatment planning purposes only. I understand that I have access to all information discussed and shared during this meeting. I also understand that my family's involvement and attendance at the meeting is necessary for my family to be involved with SOC. I accept that failure to attend could mean being discharged from SOC.*

| Parent/Guardian Signature | Date |
|---|---|
| | |

| First Meeting Date and Time | Date of Next SOC |
|---|---|
| | |

*Please fax completed form to _____*

*Attn: Your System of Care Point Person _____*