Counseling4Kids Referral Form

Burbank (818) 441-7800 Fax (818) 441-0013
Torrance (310) 817-2177 Fax (310) 817-2178
E-Mail: referrals@counseling4kids.org

REFERRAL WILL BE RETURNED IF NOT SUBMITTED WITH THE FOLLOWING NEEDED DOCUMENTS

Voluntary OR Investigation	Court Ordered	MAT Assessment
PAPERWORK NEEDED: • Completed Referral • Custody paperwork (if applicable) • Copy of Medi-Cal card • Copy of child's social security card • Copy of driver's license or I.D.	**PAPERWORK NEEDED:** • Completed Referral • Minute Order, Stand Alone, or MH-179 • Detention Report (if available) • Copy of Medi-Cal card	**PAPERWORK NEEDED:** • Completed Referral • Initial Assessment • Summary of Findings • Court documents • Copy of Medi-Cal card

School Site: ___________________________ Teacher:__________________________ Date of Request: ___________
Child Name: _____________________________________ DOB: _________ Age_____ Gender_____ Grade_____
Address: ____ Race/ Ethnicity___________
Street City State Zip
Parent/ Guardian Name: ____ Primary Language: ___________________
Biological Parent ☐ Adoptive Parent ☐ Legal Guardian ☐ Foster Parent ☐ Relative Caregiver
Relative Caregiver (relative placement) ☐ Non-Related Extended Family Member (NREFM)
Phone No: _____________________________________ (Home/ Cell) Email: _________________________________
Medi-Cal Eligible: ☐ Yes ☐ No Medi-Cal Number: _______________________________ Issue Date: _____________
Social Security Number: ____
Description of Concern/ Problem:____
____
Trauma History ☐ Yes ☐ No If Yes Please describe: ____
____
Does the Child Take Psychiatric Medication? ☐ Yes ☐ No

IMPORTANT CONCERNS

__ ***Homicidal/Suicidal*** __ ***Self-injuries*** __ ***Sexualized Behaviors***

__Sad/Depressed	__Cruel to Animals	__Bullying	__Destructive to property
__Frustrated/Agitated/Angry	__Withdrawn/shy	__Substance Issues	__Poor Concentration
__Hyperactive	__Nervous/Anxious	__Unstable living conditions	__Frequent Daydreaming
__Grief/Loss	__Low-Self Esteem	__Mood swings	__Easily Distracted
__Fidgety	__Fatigue	__Family Violence	__Sleeping Problems
__Death or loss	__Hallucinations/Delusions	__Fire Setting	__Lacks motivation in school
__Defiant	__Eating Problems	__Other ________________	

Referring Party: __Self __CSW __SFC __MAT Assessor Title/Name: ________________________
Phone Number: ___________________________________ Ext. _______Email: ____________________
Social Worker Name: _____________________________________ Open DCFS Case ☐ Yes ☐ No
Phone Number: ____ Email: _________________________

FOR OFFICE USE ONLY	FOR OFFICE USE ONLY
INCOMPLETE ☐ COMPLETE X__________________________ DATE_____________	DATE COMPLETED ________________________