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) • Child's social security number • Copy of driver's license or I.D.	**PAPERWORK NEEDED:** • Completed Referral • Minute Order, Stand Alone, or MH-179 • Detention Report (if available)	**PAPERWORK NEEDED:** • Completed Referral • Initial Assessment • CANS • Summary of Findings • Court documents

Preferred Method of Communication: ☐ **Email** ☐ **Phone** **Best Contact Time Between 8am -5pm:** _____

School Site: _____ Teacher:_____ Date Received: _____
Child Name: _____ DOB: _____ Age_____ Gender_____ Grade_____
Race/ Ethnicity (Specify if Hispanic/Origin) _____ Primary Language: _____
Is child born in the U.S.? ☐ Yes ☐ No
Address: _____
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: _____
Mother's name (Maiden):_____
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 child take Psychiatric Medication ☐ Yes ☐ No
Does the Child have a safety plan? ☐ Yes ☐ No If Yes, what was the date? _____

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: _____