Counseling4Kids Referral Form

Glendale (818) 441-7800 Fax (818) 662-6968
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

Best Contact Time Between 8am -5pm: _____ Mode Preference: ☐ Telehealth ☐ In Person ☐ In Office
Days & Times Available for Sessions: _____

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? _____
For clients 18 years+, does client have an advance health care directive in place? ☐ Yes ☐ No

IMPORTANT CONCERNS

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

__ Sad/Depressed	__ Cruel to Animals	__ Bullying Others	__ Destructive to property
__ Frustrated/Agitated/Angry	__ Withdrawn/shy	__ Being Bullied	__ Poor Concentration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 _____	__ Substance Issues

Referring Party: __ Self __ CSW __ SFC __ MAT Assessor Title/Name: _____
Phone Number: _____ Ext. _____ Email: _____
Social Worker Name: _____ Open DCFS Case ☐ Yes ☐ No
Phone Number: _____ Email: _____