Scheduled Date & Time: _____

Fernandez Community Center

Date of Referral: _____

Referral Form

Referring Agency /Person: _____ **Phone:** _____ **MR #**_____

Service(s) Requested:

__Anger Management	__Cannabis Youth Treatment	__Dialectical Behavior Therapy	__Group Therapy
__Outpatient Therapy	__Psychiatric Services	__Responsible Parenting Group	
__ Substance Abuse Tx	__Seeking Safety Group	__Abuse Bystander Group	
__Motivational interviewing	__Clinical Assessments	__Illness Management and Recovery	
__ Peer Support			

Client Full Name: _____ DOB:_____

Social Security #: _____ Age: _____

MID #/ HC#: _____ Gender: _____

Insurance Type : _____ Race: _____

Guardian Name: _____ Telephone :_____

Address: _____ City/State/Zip Code: _____

Current School: _____ Employed: __Unemployed: __

Present Grade Level: _____

Consulting Provider: _____ **Legal Involvement:** ___Yes ___No

Phone: _____ **DSS Involvement:** ___Yes ___No

Current Medication(s):_____

Reasons for referral/Presenting Problem(s):