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Date received: _____
Case #: _____
x-reference #: _____
for FSN use only

REFERRAL FORM

Parent/Guardian Name: _____	Birthdate: _____	Race: _____
Address: _____	<input type="checkbox"/> City	<input type="checkbox"/> County
Home Phone: _____	Work & Work Phone: _____	Cell/Other Phone: _____
Days / Times available: _____	School District: _____	

Children / Others in household:			
<u>Name</u>	<u>Relationship (to above)</u>	<u>Birthdate</u>	<u>Race</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

Reason(s) for Referral:

<input type="checkbox"/> Family Disorganization	<input type="checkbox"/> Family Violence	<input type="checkbox"/> Health Problem (Parent)	<input type="checkbox"/> Health Problem (Child)
<input type="checkbox"/> Mental Illness (Parent)	<input type="checkbox"/> Mental Illness (Child)	<input type="checkbox"/> MR/DD (Parent)	<input type="checkbox"/> MR/DD (Child)
<input type="checkbox"/> Parenting Practices	<input type="checkbox"/> School Problem	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Other _____

Briefly describe current situation: _____

If any family member has an Autism, Cerebral Palsy, Epilepsy, Learning Disability or Mental Retardation diagnosis, please indicate or if family member is a client of the Regional Center or City DD Office, please indicate the diagnosis:

<u>Name</u>	<u>SS#</u>	<u>Diagnosis</u>	<u>Regional Center or City Office for DD Resources?</u>
_____	_____	_____	_____
_____	_____	_____	_____

Please check all factors that are present at time of referral:

Child/Youth Characteristics: Infant w/ High Needs Child (Birth to 4) Child (5 to 7) Child w/ Challenging Temperament
 Child w/ Behavior Problems Child w/ Mental Illness Child w/ Chronic/Serious Illness
 Child w/ Disability

Parent Characteristics: Teen Parent Single Parent Parent w/ Past History of Abuse Poor Parenting Skills
 Poor Coping Skills Uses Harsh Discipline Mental Illness Mental Retardation/Disability
 Substance Abuse Relationship Problems Domestic Violence Education Under 12 Yrs.

Family Characteristics: Financial Problems Unemployment Lack of Support System
 Poor Living Conditions Homelessness History of Hotline Calls

Other Important Characteristics (Please List): _____

What other services is the family receiving? _____

Referral Source:

Agency / Organization:

Contact Number:

E-Mail:

How you heard about FSN? _____

FOR FSN USE ONLY:

Waiting list time indicated at time of referral? _____

Resources given out, if appropriate _____

Total I & R Time: _____ (minutes)

Therapist assigned:

Date assigned: