Children, Youth, and Family Division

FULL CIRCLE FAMILY PROGRAM

Felton Institute| Family Service Agency of San Francisco

DIRECT REFERRAL

(Phone, Fax or in Person)

Referral Agency:_____ Date of Referral:_____

Contact Name: _____ Contact Number :__(_____) _____Ext_____

Youth Name: _____ DOB: _____/_____/_____ Sex: _____

Attending School: YES ☐ NO☐ Name of School Attending: _____ Grade: _____

Insurance: _____ SSN#: _____ BIS: _____

(Must be Medi-Cal, Healthy SF, or Medi-Cal/ Healthy SF Eligible)

Living Situation: _____

Youth residence address: _____

Parent/ Caretaker Name: _____ Contact #_____

Youth Primary Language: _____ Parent / Caregiver primary language_____

What do you anticipate as family attitude to family therapy as mode of treatment?

Please circle one: Excited Interested Willing Dis-interested Resistant

What is the presenting problem (According to referral source):

_____

_____

_____

Current risk factors (SI, HI, abuse): _____

_____

_____

Other services child and/or family are known to be receiving: _____

_____

Please fax this form (along with the supporting documentation) to Charisse Lloyd, (415) 673-2488

Please direct any questions of follow-up calls to (415) 474-7310 x 453

FOR FCFP USE ONLY:

Referral received by: _____ Date: _____

*Date of Initial Referral Agency Contact : _____ Adm. Staff Initials: _____

** Must be within 24 hours*

Assigned Clinician: _____ Date of Assignment: _____

**Date of Initial Clinician Contact with client family: _____ Clinician's Initials: _____

*** Must be within 72 hours (3 business days)*

- Please place original referral in the Referral Binder

Children, Youth, and Family Division

FULL CIRCLE FAMILY PROGRAM

Felton Institute| Family Service Agency of San Francisco

REFERRAL from SAN FRANCISCO JUVENILE PROBATION

(Phone or Fax)

Referral Agency:_____ Date of Referral:_____

Contact Name: _____ Contact Number :__(_____) _____Ext_____

Youth Name: _____ DOB: _____/_____/_____ Sex: _____

Attending School: YES ☐ NO☐ Name of School Attending: _____ Grade: _____

Insurance: _____ SSN#: _____ BIS: _____

(Must be Medi-Cal, Healthy SF, or Medi-Cal/ Healthy SF Eligible)

Living Situation: _____

Youth residence address: _____

Parent/ Caretaker Name: _____ Contact #_____

Youth Primary Language: _____ Parent / Caregiver primary language_____

YASI completed? ☐ Mental Health Flagged? ☐ Violence / Aggression Flagged? ☐

Please circle all area(s) of primary risk/ concern:

Legal History Family School Community/ Peer Alcohol/ Drugs

Mental Health Violence/ Aggression Attitudes Skills Employment/ Free Time

Briefly describe the Primary family, social and behavioral issues that resulted in court involvement:

_____

_____

_____

Briefly describe family strengths:

_____

_____

_____

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Children, Youth, and Family Division
FULL CIRCLE FAMILY PROGRAM
Felton Institute| Family Service Agency of San Francisco

OUTSIDE REFERRAL

(Phone, Fax or in Person)

☐ School ☐ Foster Care Mental Health ☐CARC ☐ AB3632 ☐ Other _____

Referral Agency:_____ Date of Referral:_____

Contact Name: _____ Contact Number :__(_____) _____Ext_____

Youth Name: _____ DOB: _____/_____/_____ Sex: _____

Attending School: YES ☐ NO☐ Name of School Attending: _____ Grade: _____

Insurance: _____ SSN#: _____ BIS: _____

(Must be Medi-Cal, Healthy SF, or Medi-Cal/ Healthy SF Eligible)

Living Situation: _____

Youth residence address: _____

Parent/ Caretaker Name: _____ Contact #_____

Youth Primary Language: _____ Parent / Caregiver primary language_____

What do you anticipate as family attitude to family therapy as mode of treatment?

Please circle one: Excited Interested Willing Dis-interested Resistant

What is the presenting problem (According to referral source):

_____
_____
_____

Current risk factors (SI, HI, abuse): _____
_____
_____

Other services child and/or family are known to be receiving: _____
_____

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FOR FCFP USE ONLY:

Referral received by: _____ Date: _____
*Date of Initial Referral Agency Contact : _____ Adm. Staff Initials: _____
** Must be within 24 hours*
Assigned Clinician: _____ Date of Assignment: _____
**Date of Initial Clinician Contact with client family: _____ Clinician's Initials: _____
*** Must be within 72 hours (3 business days)*

- Please place original referral in the Referral Binder