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| **REFERRING AGENCY INFORMATION** |
| Referral Agency:       | Date of Referral:       |
| Contact Name:       | Contact Number: (   )    -     Ext       |
| **CLIENT DETAILS —** *Must be Medi-Cal, Healthy SF, or Medi-Cal/Healthy SF Eligible* |
| Youth Name:       | DOB:      | Sex:       |
| Attending School: [ ]  YES [ ]  NO  | Name of School Attending:       | Grade:       |
| Insurance:       | SSN#:    -  -     | BIS:       |
| Living Situation:       |
| Youth Residence Address:       |
| Parent/Caretaker Name:       | Parent/Caretaker Contact#: (   )    -     |
| Youth Primary Language:       | Parent/Caretaker Primary Language:       |
| **REASONS FOR REFERRAL** |
| What do you anticipate as family attitude to family therapy as mode of treatment?*Please check ONLY ONE:* [ ]  Excited [ ]  Interested [ ]  Willing [ ]  Disinterested [ ]  Resistant |
| What is the presenting problem (according to referral source):       |
| Current risk factors (SI, HI, abuse):       |

**Please fax or email, as an encrypted file, this form along with supporting documentation to:**

fax: (415) 673-2488 • email: fcfp@felton.org

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| **FOR FCFP USE ONLY** |  |
| Referral received by:       | Date:       |
| Date of Initial Referral Agency Contact:      *Must be within 24 hours* | Adm. Staff Initials:       |
| Assigned Clinician:       | Date of Assignment:       |
| Date of Initial Clinician Contact with client’s family:      *Must be within 72 hours (3 business days)**• Please place original in the Referral Binder* | Clinician's Initials:       |