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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](mailto: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: |