# FULL CIRCLE FAMILY PROGRAM

Felton Institute’s Children, Youth, and Family Services

phone: (415) 474-7310 x 453  email: fcfp@felton.org

1663 Mission St, Suite 604, San Francisco, CA, 94103

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| **REFERRING AGENCY INFORMATION** |
| Referral Agency:        | Date of Referral:       |
| Contact Name:       | Contact Number: (   )     -     Ext       |
| **CLIENT DETAILS —** *Must be SF Medi-Cal, Healthy SF, or Medi-Cal/Healthy SF Eligible* |
| Youth Name:       | DOB:       |
| Sex Assigned at Birth:       | Gender Pronoun:       |
| Attending School: [ ]  YES [ ]  NO | Name of School Attending:       | Grade:       |
| Insurance & ID#:       | SS#:    -  -     | BIS:       |
| Living Situation:       |
| Youth Residence Address:       |
| Parent/Caretaker Name:       | Parent/Caretaker Contact#: (    )     -     |
| Are there any legal custody issues? [ ]  YES [ ]  NO |
| Youth Primary Language:       | Parent/Caretaker Primary Language:       |
| **IS THE CLIENT UNDER SIX YEARS OLD?** |
| [ ]  YES [ ]  NO If selected **YES**, the client might be eligible for Connect & Thrive (a small program within Full Circle) should the client fit the following additional criteria:  |
| Client attends one of Felton’s 4 Early Care and Education (ECE) Programs: *Select one*[ ]  Martin Luther King Center [ ]  Sojourner Truth Center[ ]  Family Developmental Center [ ]  Solmar Learning CenterClient’s caregiver receives services through: *Select one*[ ]  Felton’s Young Family Resource Center (YFRC) [ ]  Felton’s Young Adult Court (YAC) Program |
| **REASONS FOR REFERRAL** |
| What do you anticipate as a family attitude to family therapy as a mode of treatment?*Please check ONLY ONE:* [ ]  Excited [ ]  Interested [ ]  Willing [ ]  Disinterested  |
| What is the presenting problem (according to referral source):       |
| Are there current risk factors? If yes, please indicate what they are below: [ ]  YES [ ]  NO [ ]  Unknown [ ]  Suicidal Ideation [ ]  Child Abuse [ ]  Self-Harm [ ]  Other:       [ ]  Homicidal Ideation [ ]  Substance Abuse [ ]  Violent Behavior  |

# Please email, as an encrypted file, this form along with supporting documentation to: 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* | Admin Staff's Initials:       |
| Assigned Clinician:      ***\*****Please place original in the Referral Binder and upload it to Box* | Date of Assignment:       |