# FULL CIRCLE FAMILY PROGRAM

Felton Institute’s Children, Youth, and Family Services

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

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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: |
| Days Available:  Mon  Tues  Wed  Thurs  Fri  Unsure | | | | Time Available:  Morning  Afternoon | |
| Need Psychiatric Medications?  YES  NO | | Other Providers’ Name & Contact#: | | | |
| Youth Residence Address: | | | | | |
| Parent/Caretaker Name: | | | Parent/Caretaker Contact#: (    )     - | | |
| Are there any legal custody issues?  YES  NO | | | Living Situation: | | |
| 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 Center  Client’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  Recent Hospitalization  Homicidal Ideation  Substance Abuse  Violent Behavior  Other: | | | | | |

# Please email, as an encrypted file, this form along with supporting documentation to: [fcfp@felton.org](mailto:fcfp@felton.org)

|  |  |
| --- | --- |
| **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: |