Counseling4Kids – In-Home Therapy Referral Form

601 S. Glenoaks Blvd. Suite #200 Burbank, CA. 91502

Phone: (818) 333-8297 Fax: (818) 441-0013

Email: perla@counseling4kids.org

***Attention: Perla**

Child's Name _____ **DOB** _____ ☐ **Male** ☐ **Female**

Child's Ethnicity_____ **Primary Language:** ☐ English ☐ Spanish ☐ Other: _____

Medi-Cal CIN#_____ **Child's Social Security #** _____

School _____ **Grade**_____

URGENT TREATMENT NEEDED ☐ Recent hospitalization ☐ Suicidal ☐ Risk of losing placement

Explain urgency: _____

_____

_____

****Does client currently take psychiatric medication?** ☐**Yes** ☐**No**

****Is there an urgent need for a psychiatric medication appointment?** ☐**Yes** ☐**No**

Explain urgency: _____

_____

Trauma History: ☐ Witnessed Domestic Violence ☐ Severe Neglect ☐ Physical Abuse ☐ Sexual Abuse

Describe Client's Trauma History: _____

_____

_____

Mental Health Symptoms :(check all that apply): ☐ Suicidal ☐ Homicidal ☐ Self-harm: _____

☐ Depressed ☐ Nightmares ☐ Anxious/fearful ☐ Anger Outbursts/Tantrums ☐ Isolates

☐ Inappropriate sexual behaviors ☐ Defiant ☐ Substance Abuse _____

☐ Avoids thoughts/places/people related to trauma ☐ Can't stop thinking/talking about trauma

☐ Property destruction ☐Fire-setting ☐ Cruel to animals ☐ Emotionally "numb" ☐ ADHD

Additional symptoms/info:_____

_____

_____

Open DCFS Case? ☐ Yes ☐ No

Children's Court Case? ☐ Yes ☐ No

Voluntary/Community? ☐ Yes ☐ No

Client detained/removed from home? ☐ Yes ☐ No

Detention Date: _____

Court case open but client lives with parent (placed HOP?) ☐ Yes ☐ No

CLIENT'S HOME and CAREGIVER INFORMATION:

Client currently lives with: ☐ Biological Parent ☐ Adoptive Parent ☐ Legal Guardian ☐ Foster Parent ☐ Relative Caregiver (relative placement) ☐ Non- Related Extended Family Member (NREFM) ☐ Group Home ☐ Other (specify): _____

Caregiver's Name/s (Responsible Adult client lives with): _____

Caregiver's primary language: ☐ English ☐ Spanish ☐ Other: _____

***** If caregiver is bilingual, could they participate in services with an English only speaking therapist?*** ☐ Yes ☐ No

Biological Parents' Names: Mother _____ Father_____
(If applicable)

If Mental Health Services are ***not court ordered*** for this child, please provide the following information regarding child's parents:
Parents are: ☐ Married ☐ Never Married ☐ Divorced

Is there a custody order for client/s? ☐ Sole legal custody? OR ☐ Joint legal custody?

Client and Caregiver's Home Address:

_____
_____

Home: _____
Cell: _____

Referring Person: _____ **Are you the CSW? ☐Yes ☐No**
Name of Agency: **MAT Assessor? ☐Yes ☐No Date of SOF Mtg**: _____
Agency Address: Agency Phone: _____
Agency Fax: _____
_____ Email: _____
_____

Attorney Name (for Children's Court involved clients): _____
Court Case # _____ Phone: _____
Fax: _____

DCFS Caseworker: _____ DCFS Phone: _____
DCFS Office Address: DCFS Fax: _____
CSW Email: _____
_____
_____

PLEASE INCLUDE THE FOLLOWING DOCUMENTS TO COMPLETE THIS REFERRAL:

*****REQUIRED DOCUMENTS FOR ***VOLUNTARY/COMMUNITY CASES*****:**
☐ Referral Form ☐ Copy of Medi-Cal card ☐ Custody Order (if applicable)

*****REQUIRED DOCUMENTS FOR ***DCFS COURT CASES*****:**
☐ Referral Form ☐ Copy of Medi-Cal card or letter ☐ Jurisdiction/Disposition (PRC) or Detention Report
ONE OF THE FOLLOWING: ☐ Court Minute Order for MHS ☐ DCFS Form MH-179 ☐ MAT "Stand Alone" Order

*****REQUIRED DOCUMENTS FOR ***MAT CASES*****:**
☐Referral Form ☐ Copy of Medi-Cal card/letter ☐Detention Report/PRC ☐ SOF Report ☐ Initial Assessment
ONE OF THE FOLLOWING: ☐ Court Minute Order ☐ DCFS Form MH-179 ☐ MAT "Stand Alone" Order