Counseling4Kids – Referral Form

In-Home Mental Health Services throughout Service Area 8

20101 Hamilton Ave, Suite 160 Torrance, CA 90502
Phone: (310) 436-8928 or (310) 817-2177
Fax: (310) 817-2178 ***Attention: Billie**
Email: billie@counseling4kids.org
(please do not email referral forms; all PHI must be faxed)

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

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

CLIENT'S HOME and CAREGIVER INFORMATION:

Caregiver's Name (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

Client and Caregiver's Home Address:

Home Phone:_____

Cell Phone:_____

Referring Person: _____ **Are you the CSW? ☐Yes ☐No**

Name of Agency / Agency Address: **MAT Assessor? ☐Yes ☐No Date of SOF Mtg**: _____

Agency Phone: _____

Agency Fax: _____

Email: _____

DCFS Caseworker: _____ DCFS Phone: _____

DCFS Office Address: DCFS Fax: _____

CSW Email: _____

Biological Parents' Names: Mother _____**Father**_____

If Mental Health Services are **not court ordered** for this child, please provide the following information regarding child's parents:

Biological Parents are: ☐ Currently Married ☐ Never Married ☐ Divorced

If **Divorced**, does the custodial parent have: ☐ Sole legal custody? OR ☐ Joint legal custody?

If parents are divorced, please submit copy of custody order

Attorney Name (for Children's Court involved child): _____

Attorney Phone: _____

Court Case #: _____ Attorney Fax: _____

PLEASE INCLUDE THE FOLLOWING DOCUMENTS TO COMPLETE THIS REFERRAL:

***REQUIRED DOCUMENTS FOR VOLUNTARY CASES:**

☐ Referral Form ☐ Copy of Medi-Cal card or letter ☐ 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 ☐ DCFS Form MH-179 ☐ MAT "Stand Alone" Order

***REQUIRED DOCUMENTS FOR MAT CASES:**

☐Referral Form ☐ Copy of Medi-Cal card or letter ☐ Initial Assessment ☐Detention Report ☐ SOF Report

ONE OF THE FOLLOWING: ☐ Court Minute Order ☐ DCFS Form MH-179 ☐ MAT "Stand Alone" Order