4900 Serrania Ave, Woodland Hills, CA 91364 Phone Number (818) 657-3115 Fax (818) 444-3969

Referral Form

Identifying Information: Date_____

First Name _____ Last Name _____ DOB _____ Age _____

SS # _____ Medi-Cal # _____ Grade _____ Sex M__ F__

Primary Caregiver Information:

Name _____ Primary Language _____ Phone# _____

Address: _____ Apt# ____ City _____ Zip _____

Lives with: Bio Parent____ Adoptive Parent____ Foster Parent ____ Guardian ___ Other (specify) ____

Person Referring Case: Referred by _____ Phone # _____

DCFS Yes __ No__ Probation Yes__ No __ Contact Name/Phone # _____

Best time to reach you (Circle One) Morning Afternoon Evening

Services:

Mental Health Treatment ___ Substance Abuse Treatment ___ Case Management ___

Telepsychiatry ___ Transitional Housing/ Housing ___

Currently on medication: Yes ___ No ___ If so, please list medications: _____

Presenting Problem

_____
_____
_____
_____
_____
_____
_____

Indicate problem areas:

__ Disruptive
__ Anxious
__ School Problems
__ Abuse Physical/Sexual/Emotional
__ Anger
__ Depressed
__ Irritable
__ Suicidal thought
__ Low self-esteem
__ Legal problems
__ Substance Use
__ Difficulty sleeping
__ Trauma
__Panic attacks
__ Difficulty concentrating
__Hospitalization
__ Isolated/Withdrawn
__ Peer problems
__ Delinquent behaviors
__ Assaultive
__ Easily Distracted
__ Hallucinates
__ Lies
__ Mood swings

Office use: Contact attempt 1_____ 2_____ 3_____ 4_____ 5_____

Assigned therapist _____ EBP _____ Date Assigned: _____