Five Acres Counseling Referral Form

Date of referral

Please fax or email to Adriana Luquin. Fax 626-585-1664, email aluquin@5acres.org. phone 626-246-1712

REFERRAL INFORMATION **PLEASE PRINT NEATLY/COMPLETE ALL SECTIONS**

CHILD/YOUTH INFORMATION

Last _____ First _____ MI _____ Date of Birth ___ ___ ___ Male ☐ Female ☐

School _____ Teacher _____ Counselor _____ Grade _____

Language Spoken: ☐ English ☐ Spanish ☐ Other:_____ Active IEP: YES ☐ NO ☐ Regional Center YES ☐ NO ☐

Medi-Cal (if yes #) _____ Medi-Cal Card Issue Date_____

Social Security Number _____ _____ _____ No Insurance ☐ Other Insurance_____

PARENT/GUARDIAN INFORMATION (person(s) legally authorized to give consent)

Parent Language: ☐ English ☐ Spanish ☐ Other:_____

Parents/Guardians _____ Relationship _____ Phone # ____,_____

Address _____ City _____ Zip _____ Cell # ____,_____

If different from above

Parents/Guardians _____ Relationship _____ Phone # ____,_____

Address _____ City _____ Zip _____ Cell # ____,_____

PLEASE MARK THE REASON(S) FOR REFERRAL (Check all that apply): **PRESENTING PROBLEMS**

- ☐ lacks motivation/disengaged
- ☐ defiant of rules/authority
- ☐ short attention span
- ☐ disrupts others
- ☐ aggressive/short temper/angry
- ☐ doesn't complete assignments/low test scores
- ☐ threatening/intimidating behaviors
- ☐ doesn't take responsibility for own actions
- ☐ poor attendance/truancy
- ☐ poor or limited social skills
- ☐ anxious/nervous
- ☐ depressive symptoms/extreme sadness
- ☐ low self-esteem
- ☐ inadequate progress/risk of retention
- ☐ danger to self or others
- ☐ substance abuse
- ☐ gang involvement
- ☐ withdrawn or shy
- ☐ weapons at school
- ☐ self-injury
- ☐ other_____

FAMILY ISSUES/TRAUMATIC EVENTS

- ☐ unstable living arrangements
- ☐ report filed with DCFS/open DCFS case
- ☐ suspected abuse (physical, sexual, neglect)
- ☐ lack of parental involvement/discipline
- ☐ recent death of significant person
- ☐ addition to family- stepparent, sibling
- ☐ divorce or separation
- ☐ problems with siblings
- ☐ not living with biological family
- ☐ witness or victim of violence
- ☐ domestic violence
- ☐ other

ADDITIONAL COMMENTS/DESIRED OUTCOME?

STOP **PLEASE NOTIFY PARENT/GUARDIAN PRIOR TO SUBMITTING REFERRAL FORM** STOP

Date Notified: _____ _____ _____ Notified by:_____ Spoke to:_____

_____ **Referring Person**

_____ **Organization**

_____ **Phone #**

FOR 5 ACRES STAFF USE ONLY

Date CB rec'd:	Date sent to intake:	Intake Clinician:
Intake Assigned on:	Assigned CB Clinician:	Date Assigned to CB:
IA date:	EBP Date:	EBP: MAP PPP TF-CBT BSFT PCIT Untransformed

Welligent ☐ DMH log ☐ Referral Log ☐ School list ☐ Referral list ☐ Clinician ☐ Please see addendum