**Therapy Referral**

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| --- | --- |
| **Date of referral:** |  |
| **Insurance/Payment Source** |  |
| **County/Agency** |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Email** | **Phone** |
| **Caseworker** |  |  |  |
| **Supervisor** |  |  |  |

**Child Information**

|  |  |
| --- | --- |
| **Child Name:** |  |
| **Age/ DOB** |  |
| **DCN** |  |
| **Indicate services requested** | \_\_\_ Individual therapy  \_\_\_ Family therapy  \_\_\_ None |

|  |  |
| --- | --- |
| **Child Name:** |  |
| **Age/ DOB** |  |
| **DCN** |  |
| **Indicate services requested** | \_\_\_ Individual therapy  \_\_\_ Family therapy  \_\_\_ None |

|  |  |
| --- | --- |
| **Child Name:** |  |
| **Age/ DOB** |  |
| **DCN** |  |
| **Indicate services requested** | \_\_\_ Individual therapy  \_\_\_ Family therapy  \_\_\_ None |

**Parent Information**

|  |  |
| --- | --- |
| **Parent Name:** |  |
| **DCN:** |  |
| **Phone:** |  |
| **Attorney:** |  |
| **Indicate services requested:** | \_\_\_ Individual therapy  \_\_\_ Family therapy  \_\_\_ None |

|  |  |
| --- | --- |
| **Parent Name:** |  |
| **DCN:** |  |
| **Phone:** |  |
| **Attorney:** |  |
| **Indicate services requested:** | \_\_\_ Individual therapy  \_\_\_ Family therapy  \_\_\_ None |

|  |  |
| --- | --- |
| **Parent Name:** |  |
| **DCN:** |  |
| **Phone:** |  |
| **Attorney:** |  |
| **Indicate services requested:** | \_\_\_ Individual therapy  \_\_\_ Family therapy  \_\_\_ None |

**Placement: Phone: Child placed:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |

**Child(ren) Guardian ad Litem: Phone: Email:**

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| --- | --- | --- |
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| --- |
| **Relevant Client Demographics** *Ex: ethnicity, disability status, mental health diagnosis, etc* |
|  |

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| --- |
| **Case Goal:** |
| **Case History** |
|  |
| **Goals of Therapy** |
|  |
| **Additional Information** |
|  |

*Thank you for the referral. We will respond to you promptly!*