# South Chico Free Clinic Referral

**Referral Date**:

mm dd yy

**Client Name**:               **Gender:**   Female  Male

LAST FIRST MI

**Address:**                     **DOB:**

Street, Apt. # City ZIP mm dd yy

**Parent/Guardian Name**:        **Phone #:**        Message: Yes  No

**Relationship to youth**:  Legal Parent  Legal Guardian  CSD

**Primary language spoken in the home**:

**Ethnicity:**  Asian  Black  Latino  Native American  White Other

**School/Agency:**        **Referring Party:**

**Phone #:**        **Fax #:**        Email:

**Active IEP:**  **Y**  **N** If Yes, School Psychologist (or) Designee:      

**Primary Problem Area**:  Home  School  Legal/Criminal Justice  Work  Other:

**BEHAVIORS / PROBLEMS PRESENTED:**

**SERVICES REQUESTED** (*Please check only* ***one*** *box*):

**School-Based Counseling**  **Family Counseling**  **Vocational Training**

**Case-Management**  **Individual Counseling**  **Other**

***FOR CLINIC USE ONLY***

**To Counselor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION:**  **SERVICE START DATE:**

**Cancel:** **Date**:

|  |  |
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| **Referral Form** | **Client Name:**        **Client Number:** |