#  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**:

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