Above and Beyond Children & Community Services

Referral Form

PERSON COMPLETING FORM: _____ **TODAY'S DATE:** _____

Client's Name: _____ Date of Birth: _____

Guardian (if under 18): _____ Relationship: _____

Phone #: _____ Alt Phone #: _____ Email: _____

Address: _____ Apartment complex: _____

City: _____ Zip: _____ Pets: ☐ Yes ☐ No Type: _____

Conditions to be aware of: _____

Is the family available during the day? ☐ Yes ☐ No

If youth living at different location: Contact: _____ Phone: _____

Address: _____

Language spoken in home: _____ Bilingual needed: ☐ Yes ☐ No

Does the family require an auxiliary aid? ☐ Yes ☐ No Type: _____

Client's Race: ☐ **White** ☐ **Black or African American** ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Native Hawaiian** ☐ **Pacific Islander**

Client's self-identified gender: ☐ Male ☐ Female ☐ Transgender (male to female) ☐ Transgender (female to male) ☐ I don't know ☐ I'm not sure (not asked) ☐ Other: _____

Client's Ethnicity: ☐ **Puerto Rican** ☐ **Mexican, Mexican American or Chicano** ☐ **Cuban** ☐ **Another Hispanic, Latino or Spanish Origin (specify)** _____ ☐ **Not of Hispanic/ Spanish/Latino origin**

School: _____ Grade: _____

Point of Contact and #: _____ IEP: ☐ Yes ☐ No Type: _____

Client's Social Security #: _____ Insurance information (Provider): _____

Policy #: _____ _____

Most Recent Mental Health Diagnosis: _____

Made by: _____ Date: _____

Current Medications: _____

Substance Use / Misuse: ☐ Yes ☐ No Type: _____

Has the Client been placed outside of home previously? ☐ Yes ☐ No

When: _____ Where: _____

When: _____ Where: _____

When: _____ Where: _____

Previous or Current Services

☐ DCF involvement: When: _____ Worker: _____ Phone #: _____

☐ Dependency Case Manager: _____ Worker: _____ Phone #: _____

705 West 1st Street, Sanford Fl. 32771 ♦ cell: 407.492.8770

Please email form to services@abccsprograms.org ♦ Fax: 407-391-9035

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☐ Targeted Case Manager: _____ Worker: _____ Phone #: _____

☐ Correctional Involvement: _____ JPO/PO: _____ Phone #: _____

☐ Other Providers: Type: _____ Worker: _____ Phone #: _____

☐ Type: _____ Worker: _____ Phone #: _____

Please state why referral is being made at this time: **Please include potential risk factors. (i.e. suicide, Baker Act, hospitalization, drug abuse, domestic violence, incarceration etc.) Also, any services/supports that have been tried that were less effective.**

Recommendations: **Please indicate the type of service requesting from ABCCS- (i.e. Wraparound Care Coordination, Individual Therapy, Group Counseling, Parenting classes, Advocacy Support)**

Referral Source: _____ _____ Number: _____

Business/ Agency: _____ Email: _____

PERMISSION TO CONTACT: I understand that this release is to be used for referral purposes only to Above and Beyond: Children & Community Services, Inc and I am not agreeing to services, only to learn more about service options. This release is protected under Federal Confidentiality Regulations (Title 42, Code of Federal Regulations, Part 2 and Public Law 91-616, Sec. 33, amended by Public law 93-282, Sec. 333) and Florida State Statutes (Chapter 415.51). A general authorization for releases of medical information or other information is **not** sufficient.

I acknowledge that this Release of Information has been fully explained to me and this consent is given of my free will.

_____		_____	_____
Youth Signature	(optional unless 18)	Printed Youth	Date
_____		_____	_____
Youth's Parent/Guardian	(required)	Printed Parent/Guardian	Date

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