



HISPANIC FAMILY COUNSELING, INC.
 Orange/Seminole/Osceola/Brevard/Lake
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REFERRAL FORM

DEMOGRAPHIC INFORMATION

Name: _____ Social Security #: _____
 Parents/Caregivers Names: _____ Relationship to Client: _____
 Address: _____ City: _____
 State: _____ Zip Code: _____ Phone #: _____ Other Phone #: _____
 Email Address: _____
 Sex: M F Race: White Black Hisp. Asian/Pacific Haitian Multi-Racial Birth Date: _____ Age: _____
 Legal status: Minor in parent/guardian custody Minor in state custody Competent Adult Incompetent Adult
 School/Employer: _____ Caregiver's primary language: _____ Bilingual Required? Yes No

OTHER CURRENT SERVICES

No Current Services
 Mental Health Counseling: Name of Agency: _____ Phone: _____
 Psychiatric/Medication Services: Name of Agency: _____ Phone: _____
 Other: Name of Agency: _____ Phone: _____

REFERRAL SOURCE INFORMATION

Referring Agency: _____ Person Completing Form: _____
 Phone: _____ Fax: _____ Email: _____ Date: _____
 Services Requested: Behavior Analysis Counseling PSR Psychological Testing Other: _____

FUNDING INFORMATION

Primary Insurance Name: _____ ID#: _____
 Secondary Insurance Name: _____ ID#: _____
 Insurance Phone #: _____ Insurance Address: _____
 Authorization Info.: _____

PROBLEM DESCRIPTION

Please check the client's current behavioral/emotional symptoms (required):

- | | | | | |
|--|---|-----------------------------------|---|---|
| <input type="checkbox"/> Physical Aggression | <input type="checkbox"/> Runaway | <input type="checkbox"/> Tantrums | <input type="checkbox"/> Lying | <input type="checkbox"/> Depressed Affect |
| <input type="checkbox"/> Verbal Aggression | <input type="checkbox"/> Property Destruction | <input type="checkbox"/> Truancy | <input type="checkbox"/> Sexually Acting Out | <input type="checkbox"/> Anxious Affect |
| <input type="checkbox"/> Non-Compliance | <input type="checkbox"/> Disruptive Behavior | <input type="checkbox"/> Stealing | <input type="checkbox"/> Self-Injury/Suicidal | <input type="checkbox"/> Toileting Problems |

Other: _____
 Describe: _____

YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE USE ONLY:
 Clinician Assigned: _____ Date Assigned: _____ Licensed Evaluator: _____