REFERRAL FOR SERVICES

YOUTH / ADULT (circle one)

Date: ___/___/____ Time: ________ Weber Staff's Name: __________________________

Client's Name______________________________ Date of Birth___/___/___ Age: ____________

Address: ____

Phone: (_____) _______________ Preferred Language: ____________ Gender: ________________

SSN: _______________________ Medi-Cal #: ___________________ Issue Date: _____________

EMERGENCY CONTACT:

Name: ____

Phone: (_____) _______________ Relationship to Client: ____

REFERRAL SOURCE:

Probation _____ CSW _____ Self/Parent _____ School _____ Other: __________________

Contact: ____ Phone: (_____) ________________________

SERVICES OF INTEREST: (Please check all that apply)

◯ Drug and Alcohol ◯ Drug and Alcohol Prevention Drug of choice: ________________________

◯ Individual/Family counseling ◯ Mental Health Assessment ◯ Anger Management

◯ Parenting Classes ◯ Interested in Groups: _____________ ◯ Psychiatrist Care

◯ Community Service Worker Please indicate number of hours needed: _______________________

◯ Mandated Participation ◯ Voluntary Participation

REASON FOR SEEKING SERVICES:

____

____

____

5849 Crocker Street, Unit L
Los Angeles, CA 90003
T: (323)234-4445 F: (323)234-4477

revised 11/7/17

OFFICE USE ONLY:

- **Are you in any immediate danger of hurting yourself or others?:** **Y / N ***

  ***If yes, current location and explanation:**

  ____
  ____
  ____

  ***Please follow-up with Clinical Supervisor.**

- **Available days/times for weekly services:**

  ____

- **Additional comments:**

  ____
  ____
  ____

PROGRAMS AVAILABLE:

____BVOW ____OUTPATIENT/RRR ____SCHOOL-BASED/PEI ____WRAPAROUND

____INTENSIVE SVCS (Need impact unit referral) ____UAM ____DMC ____IY (20-wk program)

CALL LOG:

DATE	PURPOSE OF CONTACT / ACTION