TRUE COLORS
TANGIBLE CHANGE
BEHAVIORAL HEALTH SERVICES

**New Client Referral Form**

Today's Date: _____

Potential Clients Name: _____ DOB: _____

Race: _____ Sex: _____ Sexual Orientation: _____

School: _____ Grade: _____

Parent/Guardian's Name: _____ Phone: _____

Relationship to Potential Client: _____

Referring Agency: _____

Name of Referring Professional: _____ Title: _____

Phone: _____ Email: _____

Reason for Referral (Please mark all that apply) :

| | | |
|---|---|---|
| ___ Change in Behavior | ___ Bullying | ___ Self Harm Concerns |
| ___ Nervous/ Anxious | ___ Aggression | ___ Stealing |
| ___ Grief | ___ Fighting | ___ Destructive |
| ___ Loss of loved one | ___ Easily Distracted | ___ Easily Frustrated |
| ___ Constant Worries | ___ Family Concerns | ___ Academics |
| ___ Fear | ___ Personal Hygiene | ___ Absences |
| ___ Self Image | ___ Peer Relationships | ___ Tardies |
| ___ Lack of Confidence | ___ Defiant | ___ At risk of Drop out |

Additional Information:

_____

_____

Other Involved Agencies:

_____