525 Cabrillo Park Dr, #300, Santa Ana, CA 92701

REFERRAL FORM

Please FAX Referrals to: (714) 542-2793

Referral questions? Contact us at (714) 953-4455, ext. 661

Instructions: This form needs to be completed by the parent or referral source and FAXED to SFSC at Child Guidance Center. ***The parent's/guardian's signature is required to provide feedback to the referral source.***

Date:_____ Referred by:_____ Self-Referral ☐

Organization:_____ Phone #_____ e-mail: _____

Should we talk to you before we contact the client? ☐Yes ☐No

Name:_____ Gender:_____ Date of Birth:_____

Address:_____ City/Zip:_____

Home Phone #_____ Work Phone #_____ Cell Phone # _____

Safe to call Yes❒ No❒ Safe to leave messages: Yes❒ No❒

Language:_____ Availability: ☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri - ☐AM ☐PM

RELATIONSHIP TO MILITARY:

☐Self ☐Spouse ☐Domestic Partner ☐Dependent Child ☐Other: _____

MILITARY AFFILIATION:

☐Veteran ☐Active Duty ☐National Guard - State: _____ ☐Reserve: _____

BRANCH OF SERVICE:

☐ Army ☐ Marines ☐ Navy ☐ Air Force ☐Coast Guard

MILITARY VERIFICATION:

☐DD214 ☐Military ID ☐VA ID Card ☐Other: _____

FAMILY MEMBERS (Please list spouse/partner, and ALL dependent children, even if not in the home)

Name (First, Last Name)	Relationship to you	Gender	DOB	Child Contact / Custody*

***Child Contact/Custody: Full-time, Part-time, None**

REASON FOR REFERRAL (Check all that apply**)**:

☐EMPLOYMENT ☐HOUSING ☐FINANCIAL ☐ DOMESTIC VIOLENCE/PREVENTION
☐EDUCATION ☐SCHOOL ISSUES ☐CHILD BEHAVIORAL ISSUES ☐FAMILY/INDIVIDUAL COUNSELING
☐MEDICAL ☐LEGAL ☐OTHER: _____

Additional Notes: _____

I authorize Strong Families Strong Children (SFSC) to contact me in order to discuss the referral of my family for supportive services or community referrals.

⇒ **Parent/Guardian's Signature:**_____ **Date:** _____

☐Check box if consent was given over the phone

I authorize SFSC to inform the referral source whether an appointment for an evaluation was scheduled or the reason why it could not be scheduled.

⇒ **Parent/Guardian's Signature:**_____ **Date:** _____

☐Check box if consent was given over the phone

SFSC Internal Use Only

Referral received on:_____ Date contacted: _____

Disposition

□ Intake scheduled on:_____ PN:_____ CCM: _____ Family # _____

□ Referral form incomplete □ Out of County □ No minor children □ Services declined □ No response

□ Does not meet SFSC criteria □ Other: _____