HISPANIC FAMILY COUNSELING, INC.
Orange/Seminole/Osceola
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referrals@hispafam.com • www.hispafam.com

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 langauge**: _____ **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):

☐ Physical Aggression	☐ Runaway	☐ Tantrums	☐ Lying	☐ Depressed Affect
☐ Verbal Aggression	☐ Property Destruction	☐ Truancy	☐ Sexually Acting Out	☐ Anxious Affect
☐ Non-Compliance	☐ Disruptive Behavior	☐ Stealing	☐ Self-Injury/Suicidal	☐ Toileting Problems

Other: _____

Describe: _____

YES	NO		YES	NO	
☐	☐	Caused injury (bruising/bleeding) to others in past month?	☐	☐	School placement in jeopardy? (suspended, multiple referrals)
☐	☐	Caused significant property damage (>$25) in past month?	☐	☐	Home placement at risk?
☐	☐	Are other people's safety at risk due to client's violence?	☐	☐	Serious suicidal gestures/attempts in past 6 month?
☐	☐	Arrested or serious criminal behavior in past month?	☐	☐	Admitted to a crisis unit in past 6 months?

FOR OFFICE USE ONLY:

Clinician Assigned: _____ Date Assigned: _____ Licensed Evaluator: _____