Resiliency Center

Child Referral (#___of ___)

Date:_____

Parent/Guardian Information:

Name:_____ Phone:_____

Address:_____ Primary Language:_____

City:_____ State:_____ Zip:_____

☐ Text ☐ Call ☐ Email

Best time to call:_____

Email address:_____

Client Information:

Name:_____ DOB/Age:_____ Gender:_____

School:_____ Grade:_____

Preferred Pronouns:_____

Ethnicity:_____ Primary Language: _____

Insurance Information:

Medi-Cal: ☐ Cal-Viva ☐ Anthem ☐ EAP ☐ Private insurance ☐ Private Pay

ID #:_____ Other:_____

Availability/Preferences:

Preferred Day of Appointment: ☐ M ☐ T ☐ W ☐ TH ☐ F Preferred Time:_____

Gender Preference for Therapist: ☐ Male ☐ Female ☐ Either

Session Preference: ☐ Telehealth ☐ In Person ☐ Either

Transportation: ☐ Yes ☐ No

Have you previously had therapy? ☐ Yes ☐ No

If yes, provide diagnosis?_____

Do you take psychiatric medication (s)? ☐ Yes ☐ No

Which medication (s)?_____

Areas of Concern/Risk:

☐ Suicide ideation ☐ Self-harm ☐ Trauma ☐ Grief/Loss ☐ Domestic Violence ☐ Human Trafficking

Please briefly describe presenting concerns:_____

_____

Do you have a safety plan? ☐ Yes ☐ No Restraining Order: ☐ Yes ☐ No Custody Order: ☐ Yes ☐ No

Fees for service:

Student Intern: $40 Registered Associate Therapist: $80 Licensed Therapist: $120

Referral Source:

Name:_____ Agency:_____

Phone Number:_____ Email Address:_____

Email: Referral@FresnoRC.org Tel: (559) 492-2266 Fax: (559) 492-2903 Address: 3845 N. Clark St., Suite #201 Fresno, CA 93726