Resiliency Center

REFERRAL

Date: ☐ Minor ☐ Adult ☐ Family: of

Parent/Guardian Information

Name: Contact #:

Client Information

Name: Gender:

DOB: Age: Preferred Pronouns:

Ethnicity: Primary Language:

School Attending: Grade:

Employer:

Home Address:

City: State: Zip Code:

OK to send mail? ☐ YES ☐ NO

Are messages ok? ☐ YES ☐ NO Best time to call:

OK to receive text messages? ☐ YES ☐ NO

Email:

OK to receive emails? ☐ YES ☐ NO

Insurance Information

Medi-Cal/CalViva: ☐ YES ☐ NO If yes, ID #:

CalVCB ID #:

Other:

Preferred days & times for sessions: ○M ○T ○W ○Th ○F ○Morning ○Afternoon ○Evening Time:

Clinician Preference: ☐ Male ☐ Female ☐ Either

Session type: ○ In person ○ Teletherapy

Have transportation? ○ YES ○ NO

Appointment Reminder (can check multiple): ☐ Text Message ☐ Email ☐ Phone Call

Area(s) of concern

(check any applicable):

☐ Trauma Victim ☐ Family/Relationship Concerns ☐ Human Trafficking

☐ Trauma Witness ☐ Runaway ☐ Bullying

☐ Grief Counseling ☐ Child Neglect ☐ Mental Health:

☐ DV Exposure ☐ Physical Abuse

Please briefly describe presenting concerns:

Suicidal Ideations? ○ YES ○ NO

Plan? ○ YES ○ NO

Have you ever received counseling before? ○ YES ○ NO

If yes, did your previous counselor give you a diagnosis? What were the issues you were being seen for?

Do you have a Safety Plan? ○ YES ○ NO

Restraining Orders? ○ YES ○ NO

Custody Order: ○ YES ○ NO ☐ Legal Custody: ☐ Physical Custody:

Fees for Service:

Practicum Student: **$40** LMFT/LPCC/LCSW: **$120** Registered Associate: **$80**

Referral made by:

Contact #: Agency:

Email Address:

Referrals can be submitted through email @ referral@fresnorc.org or fax @ 559-492-2903