Resiliency Center | First Responders for Children Impacted by Emotional Trauma

REFERRAL

Date: _____ ☐ Minor ☐ Adult ☐ Family: _____ of _____

Client Information
Name: _____
DOB: _____ Age: _____ Gender: _____ Preferred Pronouns: _____
Ethnicity: _____ Primary Language: _____
School Attending: _____ Grade: _____
Employer: _____
Home Address: _____
City/State: _____ Zip Code: _____
OK to send mail? ☐ YES ☐NO

Parent/Guardian
Name: _____ Contact #: _____
OK to leave a message? ☐ YES ☐ NO Best time to call: _____
OK to receive text messages? ☐ YES ☐ NO
Email: _____
OK to receive emails? ☐ YES ☐ NO

Insurance
Medi-Cal/CalViva: ☐ YES ☐ NO If yes, ID #: _____
CalVCB ID #: _____
Other: _____
Preferred days & times for sessions: _____
Clinician Preference: ☐ Male ☐ Female ☐ Either

Session type: ☐ In person ☐ Teletherapy
Have transportation? ☐ YES ☐ NO
Appointment Reminder (can check multiple): ☐ Text Message ☐ Email ☐ Text/Phone Call & Email

Area(s) of concern (check any applicable):
☐ Trauma Victim ☐ Human Trafficking ☐ Family/Relationship Concerns
☐ 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** Registered Associate: **$80** LMFT/LPCC/LCSW: **$120**

Referral made by: _____ Agency: _____
Contact #: _____
Email Address: _____

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