Resiliency Center

First Responders for Children Impacted by Emotional Trauma

REFERRAL

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

Client Information

Name: _____

DOB: _____ Age: _____ Gender: _____

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:

_____

_____

_____

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 #: _____ Want Follow up? ☐ YES ☐ NO

Email Address: _____

Referrals can be submitted through email: referral@fresnorc.org

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