SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

BERNALILLO COUNTY REFERRAL
FAX TO: (505) 830-0040

SERVICES REQUESTED: ☐Office-Based: Individual/Family ☐MST ☐MST-PSB
☐Thriving Kids ☐ Comprehensive Community Support Services (CCSS)

Date: _____ Time: _____

Referral Source: _____ Organization: _____

Phone #:_____ Email Address: _____

REASON FOR REFERRAL

☐ Legal Involvement. Charged with: _____
☐ Problem Sexual Behavior. Brief description:_____

☐Physical Aggression ☐Verbal Aggression ☐Academic Issues ☐Substance Use/Abuse
☐Running Away ☐Family Conflict Negative ☐Negative Peer/Gang Involvement
OTHER ☐ Describe _____
_____

Do we need to get back with referral source for any reason: NO☐ YES☐ If YES: a signed *Authorization to Release Health Information* **MUST** be included in order to contact referral source.

CLIENT INFORMATION

Name: _____ DOB: _____ Age: _____

SS#:_____ Spanish Speaking Therapist Required: YES☐ NO☐

Client's Legal Guardian's Name: _____

Relation to client: _____Telephone#: _____

If legal or CYFD Involvement, FACTS #: _____

STATUS OF LIVING SITUATION AT TIME OF REFERRAL:
☐At Home With Caregiver ☐Living With Other Family Members
☐ In Detention ☐ In Residential Treatment ☐In TFC ☐ In Shelter

PAYMENT INFORMATION

Client is legal US Resident: Yes ☐ No ☐
Client has Medicaid: Yes ☐ No ☐ IF YES: Medicaid #:_____
Centennial Healthcare#:_____ Recertification Date: _____

FOR INTERNAL USE

Forwarded to: _____ on _____

By:_____ ☐ Email ☐ Placed In Agency Mailbox