SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

BERNALILLO COUNTY REFERRAL
FAX TO: (505) 288 3493

SERVICES REQUESTED: ☐ Office-Based ☐ MST ☐ MST-PSB ☐ IOP ☐ Assessment Only
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:

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