SANDOVAL COUNTY REFERRAL
FAX TO: 505-333-0558

SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

SERVICES REQUESTED:
☐ Office-Based: Individual/Family ☐ Drug Court/IOP
☐ Assessment Only ☐ MST ☐ MST-PSB

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

☐ **Kristy Souza, LMFT**
Lead Clinical Supervisor Corrales Office
Treatment Drug Court Supervisor
Phone: 505-385-0439 Fax:505-433-4486
Email: ksouza.swfgc@gmail.com

☐ **April Casuse, LMFT**
MST Supervisor Sandoval
JJS Referral Coordinator
Phone: 505-250-6233 Fax:505-333-0558
Email: acasuse.swfgc@gmail.com