

SOUTHWEST FAMILY

GUIDANCE CENTER & INSTITUTE

BERNALILLO COUNTY REFERRAL

FAX TO: (505) 830-0040

SERVICES REQUESTED: Office-Based: Individual/Family MST MST-PSB Thriving Kids
 Substance Use/Abuse Programs (ISAP) 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: _____ on _____

By: _____ Email Placed In Agency Mailbox