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 ____

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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

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