SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

PLEASE FAX TO (505) 830-0040

DATE _____

TIME _____

REFERRER _____

ORGANIZATION _____

PHONE _____

EMAIL _____

SERVICES REQUESTED

- ☐ OFFICE-BASED: INDIVIDUAL/FAMILY
- ☐ TREAT FIRST
- ☐ MULTISYSTEMIC THERAPY (MST)
- ☐ PROBLEM SEXUAL BEHAVIOR (MST-PSB)
- ☐ THRIVING KIDS PARENTING PROGRAM
- ☐ FOSTERING FAMILY
- ☐ INFANT MENTAL HEALTH (IMH)
- ☐ COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS)

REASON FOR REFERRAL

☐ **Legal Involvement. Charged with:** _____

☐ **Problem Sexual Behavior. Describe:** _____

☐ **Physical Aggression** ☐ **Verbal Aggression** ☐ **Academic Issues** ☐ **Substance Use/Abuse**

☐ **Running Away** ☐ **Negative Family Conflict** ☐ **Negative Peer/Gang Involvement**

☐ **Other:** _____

CLIENT INFORMATION

NAME _____ **DOB** _____ **AGE** _____

SSN _____ **SPANISH-SPEAKING THERAPIST REQUIRED?** ☐ **YES** ☐ **NO**

LEGAL GUARDIAN _____

RELATION TO CLIENT _____ **PHONE** _____

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**

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PAYMENT INFORMATION

CLIENT IS LEGAL U.S. RESIDENT? ☐ YES ☐ NO

CLIENT HAS MEDICAID: ☐ YES ☐ NO

IF YES: MEDICAID # _____

CENTENNIAL HEALTHCARE # _____

RECERTIFICATION DATE _____

CLIENT HAS ACCEPTED PRIVATE INSURANCE?

☐ **Blue Cross & Blue Shield**

☐ **Presbyterian Health Plan**

☐ **United Healthcare**

☐ **Other Insurance**

☐ **No Insurance**

ADDITIONAL FAMILY MEMBERS TO INCLUDE (IF ANY)

NAME _____ **DOB** _____

NAME _____ **DOB** _____

NAME _____ **DOB** _____

NAME _____ **DOB** _____

NAME _____ **DOB** _____

ADDITIONAL NOTES (OPTIONAL):

NOTIFICATION:

DO WE NEED TO GET BACK WITH REFERRAL SOURCE FOR ANY REASON? ☐ YES ☐ NO

If yes, a signed authorization to release health information must be included.

INTERNAL USE ONLY

FORWARDED TO _____ **DATE** _____

BY _____ ☐ **IN WELLIGENT** ☐ **IN AGENCY MAILBOX**