REFERRAL TO THE FEDERATION OF FAMILIES OF SC

REFERRAL DATE: ______________________

FAMILY CONTACT INFORMATION:

NAME (PARENT/GUARDIAN): ______________________

ADDRESS: ______________________ **City:** ______________ **State, Zip:** ____________

COUNTY: ______________________ **RACE/ETHNICITY:** ______________________

HOME PHONE: ______________________ **CELL PHONE:** ______________________

WORK PHONE: ______________________ **EMAIL:** ______________________

PARENT/GUARDIAN'S PRIMARY LANGUAGE: ______________________

CHILD'S NAME: ______________________ **CHILD'S DOB:** ______________________

CHILD'S NAME: ______________________ **CHILD'S DOB:** ______________________

CONSENT FOR RELEASE OF CONTACT INFORMATION—SIGNATURES REQUIRED

______________________ **PARENT/LEGAL GUARDIAN**

______________________ **CHILD IF OVER 16 YEARS OF AGE**

______________________ **CHILD IF OVER 16 YEARS OF AGE**

REFERRAL SOURCE CONTACT INFORMATION:

NAME: ______________________ **TITLE:** ______________________

AGENCY: ______________________ **COUNTY:** ______________________

PHONE: ______________________ **EMAIL:** ______________________

REASON FOR REFERRAL: ______________________

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AGENCIES OR SYSTEMS KNOWN TO BE INVOLVED WTH THE FAMILY:

PLEASE CHECK WHICH SYSTEMS ARE INVOLVED IN DELIVERING SERVICES TO YOUR CLIENT

☐ **MENTAL HEALTH** ☐ **ALCOHOL & DRUG ABUSE** ☐ **JUVENILE JUSTICE**

☐ **CONTINUUM OF CARE** ☐ **JUVENILE JUSTICE** ☐ **DSS**

☐ **EDUCATION** ☐ **PROBATION/FAMILY COURT** ☐ **HOMELESS SERVICES**

☐ **HOUSING** ☐ **PRTF** ☐ **OTHER:** ______________________

Please FAX form to 803-772-5212
Call us toll-free: 866-779-0402
For additional forms, please visit https://goo.gl/c67fDV.

Federation of Families of South Carolina

A Voice for Children's Mental Health in SC