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: _____

_____

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 click here.

Federation of Families of South Carolina
A Voice for Children's Mental Health in SC