Coastal Horizons
Promoting Choices for Healthier Lives and Safer Communities

Internal Use Only:
Received By: _____ On: _____
Date Contacted Referral Source: _____
Date Contacted Family: _____

Lake Forest Day Treatment Referral Form

Client Name: _____ Date of Birth: _____ Age: _____ Race: _____

School: _____ School ID: _____ Grade: _____ School Contact: _____

SS# _____ LME Record # _____ Primary Language: _____

Gender: _____ Insurance Type: _____ Insurance # _____

Legal Custodian: _____ Relationship: _____

Client Address (Where services will likely take place): _____

Current Placement (i.e. Home, PRTF, Treatment Facility) _____

Phone # (home): _____ Work #: _____ Cell#: _____

Best time to contact family? _____ and Referral Source? _____

Referral Contact Name/Phone Number: _____

Current Medication(s): _____

Reason for Referral

- ☐ Substance Use
- ☐ Impulsivity
- ☐ Anxiety
- ☐ Other -
- ☐ Truancy
- ☐ Runaway
- ☐ Depression
- ☐ Defiance
- ☐ Trauma
- ☐ Suicidal/Homicidal Ideations
- ☐ DSS Involvement
- ☐ Sexually Inappropriate Behaviors
- ☐ Aggression
- ☐ DJJ Involvement

_____

Briefly explain reason for referral: _____

_____

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Please Fax Referrals to (910) 772-2516