Coastal Horizons

*Promoting Choices for Healthier Lives and Safer Communities*

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

# Community Based Family Services Referral Form

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

SS# _____ LME Record # _____ Primary Language: _____

Gender: _____ Insurance Type _____ Insurance # _____

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Legal Custodian: _____ Relationship: _____

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

Is the child planned to remain at this location during treatment? _____

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: _____

Adult(s) who will be involved in services and relationship to child _____

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Current Medication(s): _____

Service Preferences: ☐ TFCBT ☐ Substance Abuse ☐ Race: _____ ☐ Sex: _____

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**Reason for Referral**

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

_____

**Briefly explain reason for referral:** _____

_____

_____

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_____

**Please send referral and accompanying documents to: Coastal Horizons Center: FAX: 910-202-5772**