

CHILD FIRST REFERRAL FORM

REFERRAL SOURCE

Referrer Name: _____

Agency/Organization (if applicable): _____

Phone: _____

Email: _____

Referral Source Type:

- ☐ Self/Family ☐ Healthcare Provider ☐ Mental Health Provider ☐ Child Welfare/CPS
☐ School/Early Childhood Program ☐ Court System ☐ Home Visiting Program
☐ Community Organization ☐ Shelter/DV Program ☐ Other: _____
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CHILD & FAMILY INFORMATION

Child Name: _____

DOB: ____ / ____ / ____

Child Race: _____

Child Ethnicity: _____

Parent/Caregiver Name: _____

Relationship to Child: _____

Phone: _____

Address: _____

Is the person mentioned above the legal guardian? ☐ Yes ☐ No

If no, please list legal guardian _____

Phone: _____

Address: _____

Is this the location services will take place? ☐ Yes ☐ No

If no, please list address for services _____

Primary Language: _____

Insurance: ☐ Medicaid ☐ Private ☐ None ☐ Unknown

REASON FOR REFERRAL (Check all that apply)

- ☐ Developmental/Educational Concerns
☐ Child Behavioral/Emotional Concerns

- ☐ Parenting Support Needed
- ☐ Mental Health Concerns
- ☐ Substance Use Concerns
- ☐ Housing/Basic Needs
- ☐ Domestic Violence Exposure
- ☐ Abuse/Neglect Concerns
- ☐ Risk of Placement or School/Childcare Expulsion
- ☐ Service Coordination Needed
- ☐ Other: _____

CURRENT SERVICES INVOLVED (Add Name of Provider)

- ☐ Healthcare Provider _____
- ☐ Mental Health Provider _____
- ☐ School/Early Childhood Program _____
- ☐ Child Welfare/CPS _____
- ☐ Home Visiting Program _____
- ☐ Other: _____
- ☐ None

BRIEF REFERRAL SUMMARY

Reason for referral:

Referral Completed By: _____

Date: ____ / ____ / ____

Is the family aware that referral is being sent? ☐ Yes ☐ No

PLEASE RETURN TO: Fax completed referral forms to 910-202-5772 (Attention: Child First) or email to cbfsadmin@coastalhorizons.org.