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: _____

CHILD & FAMILY INFORMATION

Child Name: _____

DOB: ____ / ____ / _____

Gender: _____

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.