THE CHILDREN & TEENAGERS FOUNDATION, INC.

Providing alternatives to hopelessness and solutions for tomorrow.

Child & Adolescent Services

CORE Referral Form (rev 05.03.2018)

Adult Services
Life's Journey

Upon receipt of this form a C&T representative will contact the family within 24hrs.

Date of Referral:		**Date Referral Received &Staff Initials:**	
Person Referred for Services:			
☐ **Person referred is 17 years old and under**		☐ **Person referred is 18 years old and over**	
Name:		DOB:	
Address:		Gender:	
City, Zip:		County:	
Home #:		Cell #:	
Alt #:		Work #:	
Legal Information:			
Is The Person Currently on Probation or involved with DJJ ☐Yes ☐No		Name of P.O. or DJJ Worker :	
Contact Information: (W):		Email:	
Emergency Contact Information:			
Name:	Relationship:	No #:	
Insurance Type: Insurance #:			

☐Traditional Medicaid ☐Amerigroup ☐Cenpatico ☐ Wellcare ☐Caresource ☐None ☐Private Insurance

Reason for Referral: *(Primary reason seeking services/List Current Behaviors & Medications)*

Has Psychological Evaluation been completed? ☐Yes ☐No Has a Psychiatric Evaluation? ☐Yes ☐No Is Consumer CURRENTLY prescribed Medication? ☐Yes ☐No	***Please submit supporting documents (Psychological, Psychiatric, Discharge Paper and any other pertinent testing).***

Services Requested (Select all that apply):

Note: Services available will be dependent upon client's insurance type

Available for C&A and Adults	*****Adults Only*****
☐Diagnostic Assessment ☐Medication Management ☐Nursing Assessment/Care ☐Psychological Evaluation ☐Individual Therapy ☐Family Therapy ☐Psychiatric Evaluation ☐Community Support (CSI) ☐Group Therapy ☐	☐Case Management ☐Psychosocial Rehabilitation(PSR-I) ☐Addictive Disease Supports ☐Peer Support Services

Referral Source Information (Complete only if referral source is other than Parent/Legal Guardian):

Name:	Relationship:
Agency:	Email:
Position:	Phone:
Supervisor Name:	Supervisor Phone:

How did you hear about our agency? ☐School Referral ☐DFCS Referral ☐DJJ Referral
☐Family Member/Friend ☐Insurance Company ☐Doctor's Office ☐Website/Internet ☐Other:

*****Complete if Person Referred is under 18:*****

Name of Caregiver:		Relationship:	
Contact Information: (H):		(C):	
Is this the consumer's legal guardian? ☐Yes or ☐No			
If NO, specify legal guardian name (If different from Referral Source):			Relationship:
Contact Information: (H):	(C):	(W):	Email:

PLEASE RETURN REFERRAL TO:

Email: referrals@catfoundation.com Or Fax: (404) 299-3564