CITY IMPACT COUNSELING CENTER

829 North "A" Street, Oxnard, CA Phone: 983-3636
Fax (805) 988-2240 www.cityimpact.com

Today's Date: _____ **REFERRAL FORM**

Name of Client:_____Date of Birth: _____

Address: _____ City: _____ Zip: _____ Phone: _____

If client is a minor, name of Parent/Guardian _____

School: _____ Grade Level:_____ Teacher: _____

Number of people living in the home: _____ Preferred language spoken in home: _____

Does client need a bilingual counselor? YES NO Does client have Medi-Cal? YES NO

Medical #: _____ Issue Date: _____
(Please attach copy of Medical card.)

REASON FOR REFERRAL:_____

_____

PLEASE CHECK ANY HIGH RISK CHARACTERISTICS:

____ Nightmares
____ Defiance/breaking rules
____ Inability to get along
____ Frequent temper tantrums
____ Physical fighting/hitting/bitir
____ Verbally abusive
____ Sadness/lack of energy
____ Drug/alcohol use
____ Eating disorders
____ Fearful/anxious
____ Recent loss/trauma
____ Crying Spells

____ Disheveled appearance
____ Stealing/Lying
____ Physical/sexual abuse or neglect
____ Poor hygiene
____ Decline in classroom Performance
____ Disruptive in class
____ Falls asleep/lethargic in class
____ Lack of concentration/inattentive
____ Unable to sit still
____ Difficulty following instructions

____ Clinging/shadowing others
____ Excessive need for reassurance
____ Isolated/withdrawn
____ Overly concerned with pleasing others
____ Puts self down frequently
____ Scapegoat/picked on
____ Irritable
____ Suicidal/Homicidal thoughts
____ Distancing parents
____ Parental drug/alcohol abuse
____ History of parental abuse

Name and title of Referring Party _____ at _____
(Print) (Name of Agency, Organization, School, etc)

Phone #_____ Fax #_____

Release of Information:
I hereby authorize the release of above information to and from City Impact, Inc. for the purpose of referral and service coordination with _____.
(Name of referring party, school, agency, organization, etc.)

Por la presente autorizo la liberación de información a/ y de City Impact, Inc. para la recomendación y la coordinación de servicios con _____.
(nombre de la persona, escuela, agencia, organización, etc.)

_____ _____
Signature Parent/Guardian/ *Firma del Padre, Madre o Tutor* Date/ *Fecha*

For City Impact Use Only:
Program assigned: S.P. C.D.B.G. O.P.W. T.W.

EPSDT (Child/Youth Medi-Cal) First 5 G.V.S. Triple P Private Pay

(Revised 07/10)