HEMPFIELD

BEHAVIORAL HEALTH, INC

INNOVATION ■ COMMUNITY ■ EXPERIENCE

Family Check Up Referral Form

Date: __________

Agency Referral Source: ______________________________
Agency Phone Number: ______________________________
Name of person referring client: _______________________
Email: ____

Client Information

Name of Parent/Foster Parent/Kinship Family Member: ________________________________
Date of Birth: ______________
Address: ____
Phone Number: _________________________
Other people living in the home: ____
Name of child(ren) and ages ____
Is the family aware that this referral is being made? ☐ YES ☐ NO
Do we have permission to contact this family and leave a message? ☐ YES ☐ NO
What is the best time to contact Parent/Foster Parent/Kinship Family Member?

Referral Criteria

Has the child(ren) in this referral been impacted by caregiver substance use?

- ☐ Yes
- ☐ Unsure
- ☐ No

Please provide a brief description of concerns regarding this client and the need for services:

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Please fax completed forms to *HEMPFIELD BEHAVIORAL HEALTH: 717-221-8006*