



CELINE'S FAMILY SERVICES, INC.

Servicing one Child at a time

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Decatur, GA 30034

Office: 404-214-7116 | E-Fax: 404-506-9439

Email: celinesfamilyservicesinc@yahoo.com

Program Referral Form

Referral Source _____ Referral Agency _____ Referral Date ____/____/20____

Referral Contact # _____ Referral Source Email _____

Requested Services

- Psychiatric/Psychological Evaluation
- Nursing Assessment & Care
- Crisis Intervention
- Community Support Services
- Educational Advocacy
- Life Skills Development
- Individual Counseling
- Family Counseling
- Group Counseling
- Substance Abuse Counseling

Describe the Problem

- ADHD Symptoms
- Depression
- Alcohol/Drug Use
- Oppositional
- Probation Violation
- Run Away
- Truancy
- DFCS Involvement
- DJJ Involvement
- Previous MH Treatment
- Grief/Loss
- Family Discord
- Sexual Abuse
- Physical Abuse
- Sexual Perpetration
- Reunification Plans
- Bullying
- Fighting
- Self-Harmful Behavior
- Other

Child's Name _____ Date of Birth _____
Last First MI

Child's File # _____ Social Security # _____

Medicaid Peachstate WellCare Amerigroup Other _____ Medicaid ID # _____

Is child currently on medication? Yes No If yes, Please list _____

Current School _____ Attending? Yes No Grade _____

Current IEP? Yes No Is DFCS Involved? Yes No Is DJJ Involved? Yes No

Case Worker/Officer _____ Phone # _____

Currently on probation? Yes No If yes, please specify _____

Has child received services before? Yes No If yes, please specify agency _____

Previous Psychological? Yes No If yes, please attach.

Parent/Guardian Name _____ Email _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Does Parent/Guardian Work? Yes No If yes, what days/hours _____

What outcome would you like to see? _____

Please FAX Referral Form to Celine's Family Services, Inc. at 404-506-9439

For CFS Staff Only: Was case APPROVED DENIED? Staff Initials _____ Date _____ Assigned to: _____