



hope help healing

Clinical Referral Form

Send completed form to: Referrals@mtncac.org

O (828) 213-9824 | F (828) 213-7960

***Chris Blanc (Mountain CAC Referral Specialist) coordinates all referral processing. All questions related to referrals can be addressed to Chris via the email address indicated above. Please make sure to complete all fields indicated on the referral form to ensure the referral is processed in a timely manner.**

Missing information will likely delay referral processing*

Date of Referral: _____

Referring Agency: _____
Ph #: _____

Referred by: _____
Email Address: _____

Referral is for: Child OR Adult

Client's Name: _____ DOB: _____ Gender: _____

Address: _____

Primary Language: _____

Race: _____

Insurance Type: _____

Ph # (For adult referrals): _____

Parent/Guardian Name (if applicable): _____ Relationship: _____

Ph #: _____

Email Address: _____

Best day of week & time of day to meet with Client: _____

Members of Household:

<u>Name</u>	<u>Birth date</u>	<u>Relationship to Child</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

DSS Involvement (if applicable)

Is DSS involved? No Yes – Worker: _____ Ph #: _____

If yes, Department: CPS Foster/In-Home - Email Address: _____

Additional Information

Referral Reason: Assessment Treatment Parenting

Other Reasons/Issues for Referral:

Goals & Objectives for Mountain CAC Services:

Previous Treatment that Client has Received or is Currently Receiving:

Other Agencies Involved with Child/Family:

Court Involvement (DA, Family Court, Juvenile Court Services, Custody, Other):

School Involvement (special programs, problems, contact person):

Has child had a Child Medical Evaluation (CME) No Yes (please include with referral)

PRESENTING ISSUES AT REFERRAL: If child appears to be struggling with any of the following factors, indicate by checking all that apply:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> other drug abuse | <input type="checkbox"/> inappropriate sexual behavior | <input type="checkbox"/> change in eating |
| <input type="checkbox"/> truancy | <input type="checkbox"/> runaway | <input type="checkbox"/> suicidal ideation/behavior | <input type="checkbox"/> emotional dysregulation |
| <input type="checkbox"/> learning disability | <input type="checkbox"/> emotional disability | <input type="checkbox"/> behavioral disability | <input type="checkbox"/> behavioral dysregulation |
| <input type="checkbox"/> developmental disability | <input type="checkbox"/> physical disability | <input type="checkbox"/> BEH (beh/emot handicapped) | <input type="checkbox"/> grief/loss |
| <input type="checkbox"/> sexual abuse | <input type="checkbox"/> physical abuse | <input type="checkbox"/> emotional abuse | |
| <input type="checkbox"/> neglect | <input type="checkbox"/> delinquency | <input type="checkbox"/> mental illness (specify): _____ | |
| <input type="checkbox"/> family conflict/violence | <input type="checkbox"/> school difficulty | <input type="checkbox"/> homelessness | |
| <input type="checkbox"/> illiteracy _____ | <input type="checkbox"/> withdrawn | <input type="checkbox"/> other(specify): _____ | |

Thank you for taking the time to make this referral.