Today's Date: _____ **NEW DAWN COUNSELING & CONSULTING, INC.**

1500 Camino Del Sol Suite 1 Oxnard, CA 93030
Phone (805) 604-5437 Fax (805) 307-2595 referrals@newdawncnc.com

Name of Client: _____ Ethnicity: _____ Date of Birth: _____

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

Do we have permission to leave a voicemail message on Client or Parent/Guardian's phone? Yes ☐ No ☑

If client is a minor, the name of Parents/Guardians: _____

School: _____ Grade Level: _____ Teacher: _____

Preferred language spoken at home: _____ Does client have Medi-Cal? Yes ☐ No ☑

Medi-Cal ID #: _____ Issue Date: _____ (Please attach copy of Medi-Cal card)

If client has received mental health services in the past, when _____ and where _____

REASON FOR REFERRAL: _____

_____

PLEASE CHECK ANY HIGH RISK CHARACTERISTICS:

☐ Defiance/breaking rules	☐ Fearful/anxious	☐ Poor hygiene
☐ Frequent temper tantrums	☐ Recent loss/trauma	☐ Low self-esteem
☐ Physically abusive	☐ Disheveled appearance	☐ Isolated/withdrawn
☐ Verbally abusive	☐ Stealing/lying	☐ Irritable
☐ Sadness/lack of energy	☐ Family separation	☐ Bullied
☐ Suicidal/homicidal thoughts	☐ History of neglect	☐ Disruptive in class
☐ Drug/alcohol use	☐ History of sexual abuse	☐ Unable to sit still
☐ Eating disorders	☐ History of physical abuse	☐ Lack of concentration/inattentive
☐ Nightmares	☐ Drug/alcohol use within family	☐ Decline in classroom performance

Referring Party _____ with _____
(Please print name and title) (Name of Agency, Organization, School, etc.)

Phone Number: _____ Fax Number: _____ Email: _____

How did you hear about us? _____
Referring Party's preferred method of communication: Phone ☐ Fax ☐ Email ☐

Release of Information:
I hereby authorize the release of the above information to and from New Dawn Counseling & Consulting, 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 New Dawn Counseling & Consulting, Inc. *para la recomendación y la coordinación de servicios con* _____.
(Nombre de la persona, escuela, agencia, organización, etc.)

_____ _____
Name of Parent/Guardian/ *Nombre del Padre, Madre o Tutor* Date/ *Fecha*

For New Dawn Counseling & Consulting, Inc. Use Only:
Program: ☐ EPSDT (Child/Youth Medi-Cal) ☐ Triple P-pvt pay ☐ Triple P NfL ☐ KP ☐ Beacon ☐ Private Pay