Butterfly Foundation
"Changing one life at a time"

Butterfly Foundation
Culinary Job Training Program Referral
Fax: 864-707-2224

Date of referral: _____

Name of person you are referring to the Culinary Training Program: _____

Your Name: _____ Title: _____

Agency: _____Email: _____

Office Telephone: _____Cell: _____Fax: _____

Client's Address:_____

Client's Phone:_____ Cell:_____

Reason for referral:_____

Why is this person currently under your care? _____

How long have you been working with this person? _____

How often do you meet in person? _____

How often do you communicate either via phone or e-mail? _____

Are you willing to maintain collateral support with Butterfly Foundation and attend meetings to ensure this person's success in this program? ___Yes ___No

Are there any issues that would prohibit or interfere with this person's ability to participate in the program, which is in session between 8:00 AM – 4:00 PM, Monday through Friday? ___Yes ___No

(Please specify any reasons this person may not be available during the training program)

_____

_____

Has this person ever been in a mental health or substance treatment program? ___Yes ___No

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Mental Health History

Psychiatric Agency/Facility **Dates**

1._____

2._____

SA/AA Treatment Programs

Treatment Program **Dates**

1._____

2._____

Has this person ever suffered from a trauma? ____Yes ____No

If yes, please describe the trauma history:

_____

_____

What goals are you currently working on with the client?

Goal 1_____

Goal 2_____

Are you having any challenges with this client?

1._____

2._____

Print Name_____ **Signature**_____

Date_____