mountain
child advocacy center
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. <u>Missing information will likely delay referral processing</u>

Date of Referral: _____

Referring Agency: _____ Referred by: _____
Ph #: _____ 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:

Name	Birth date	Relationship to Child
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

DSS Involvement (if applicable)

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

Email Address: _____

Additional Information

Referral Reason: ☐Trauma Assessment
☐Treatment (check all that apply): ☐TF-CBT ☐Non-Offending Parent ☐Individual ☐Family

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:

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☐illiteracy _____	☐ withdrawn	☐ other(specify): _____	

Thank you for taking the time to make this referral.