



hope help healing

### Clinical Referral Form

Send completed form to: [Referrals@mtncac.org](mailto:Referrals@mtncac.org)

O (828) 609-6222 ext. 109 | F (828) 412-0818

**\*Miranda Bingham (Clinical Family Advocate) 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:

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

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

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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.**