Family Preservation Referral

Person completing form: _____

Child's Name: _____ DOB: _____ Medicaid ID: _____

Caregiver Name(s): _____ Phone: _____

Current address: _____ Phone: _____

Open DHS case? Yes☐ No ☐ Caseworker Name &Phone: _____

Primary care doctor's name: _____ Clinic: _____

Other behavioral health providers: (therapists, psychiatrist, groups, substance abuse etc.) _____

_____

Current behavioral diagnosis: _____

Current medications: (dose & frequency): _____

Current risk factors:

Suicide Risk: none ☐ ideation ☐ intent w/o means ☐ intent w/means ☐ contracted not to harm self ☐

Victim of abuse or neglect? Yes☐ No ☐ Was it legally reported? Yes☐ No ☐

Symptoms that are the reason for referral: _____

_____

Tentative goals: _____

_____

Brief description of the following:

Family impairments/supports: _____

School: _____ IEP? Yes☐ No ☐

Housing: _____

Other medical/physical illness/needs: _____

Other services currently in place (name & number of sessions completed): _____

_____

Return to Four Feathers Counseling via fax 1-855-332-4436 or email to csupernault@fourfeatherscounseling.com