(p) 1-866-617-0065 (f) 716-833-3264
www.fosteringgood.org

Referral for Children and Family Treatment and Support Services

Youth Information

Youth Name: ______________________ Date of Referral: ______________

Gender: ☐ M ☐ F ☐ T SSN: ______________ DOB: ______________

Current Address: ______________________

City/Town ______________ County: Zip

Youth Phone *(required for youth 18+)* ______________

Who is the Medical consenter for the youth? Name: ______________

Relationship: ______________

Address: ______________

☐ *Check if same as youth* ______________

Phone (cell): Phone (home): Phone (other):

Who currently lives at home with the youth *(list names and relationship)* ______________

School most recently attended: Grade:

Current or previous Mental Health Diagnosis: ______________

Service linkages/history

Provider Type	Provider Name	Current/Past
Outpatient Clinic		
Psychiatry		
Health Home		
Social Services		
Residential		
OPWDD		
Other:		
Other:		

Risk Factors *(check all that apply):* ☐ Suicide ☐ Self-Injury ☐ violence/aggression ☐ property destruction ☐ fire setting ☐ animal cruelty ☐ inpatient psychiatric hospitalization(s) ☐ drug use ☐ Runaway Behavior

Other:

Insurance Information

Insurance Company:	Medicaid ID/CIN:	
	Policy #:	

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YOUTH AND FAMILY SERVICES
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Referral for Children and Family Treatment and Support Services

Please describe / check what services you are seeking: Other Licensed Professional (OLP), Community Psychiatric Supports & Treatment (CPST), Psychosocial Rehabilitation (PSR)	
☐ Assessment, Establish a Diagnosis (OLP) ☐ Individual and/or Family therapy (OLP) ☐ Complex Trauma Assessment-Health Homes (OLP) ☐ Behavior modification/Intensive Interventions (CPST) ☐ Interpersonal Relationships (CPST)	☐ Crisis Avoidance (CPST) ☐ Community Integration (CPST / PSR) ☐ Social / Interpersonal skills (CPST / PSR) ☐ Organizational skill development (CPST / PSR) ☐ Daily Living Skills (CPST /PSR) ☐ Skill building / Mentoring (PSR)

Please describe why you are requesting these services, what are the goal(s) for the youth:

Are there any safety concerns for the worker, providing services within the youth's home environment:

☐ No ☐ Yes: Please describe below:

Is an interpreter required? ☐ No ☐ Yes: Primary language: _____

Referral Source Information	
Name: ____________	Role/Relationship to youth: ____________
Agency/Organization: ____________	
Phone: ____________	Email: ____________
****Referrals for CPST and PSR require a recommendation from a Licensed Practitioner of the Healing Arts (LPHA) – is the recommendation attached to the referral?* ☐ Yes ☐ No ***	

Referral Consent

The person who is authorized to consent for Medical treatment is in agreement with the referral:

______________________________ ______________________

Medical Consenter Signature Date

☐ Check if verbal consent was obtained

______________________________ ______________________

Referral Source Signature Date