HAYNES
FAMILY OF PROGRAMS

MENTAL HEALTH REFERRAL FORM

CLIENT INFORMATION

Referral Date: _____

Child/Youth Name: _____ **DOB:** _____

Legal/Assigned Sex: ☐ **Male** ☐ **Female** **Gender Identity (if different):** _____

Preferred Language: _____ **Medi-cal #:** _____

Current School: _____ **Current Grade:** _____

Address: _____
Street City State Zip Code

Home Phone Number: _____ **Cell/Work Phone Number:** _____

CONTACT INFORMATION

Legal Representative's Name: _____

Address: _____
Street City State Zip Code

Home Phone Number: _____ **Cell/Work Phone Number:** _____

Preferred Language: _____

REASON FOR REFERRAL (Behaviors/Symptoms: Current medications: Medical problems/conditions, etc. they may warrant Mental Health Services.

_____
_____
_____
_____
_____
_____

Name & Title of Person Referring Client/Student: _____

Has the Legal Representative been contacted and informed of referral? Yes No

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(To Be Completed by Mental Health Only)

Referral Forwarded to (Therapist): _____ Date:_____