REFERRAL FOR SERVICES

Date of Referral: _____

Date Received: _____

Client Information

Name: _____

Date of Birth: _____ Race/Ethnicity: _____

School & Grade: _____

Gender: ❒ Male ❒ Female ❒ Other
_____

Services Requested:

❒ Healing Hearts (Children/Adolscents with a caregiver with cancer)

CONTACT INFORMATION:

Home: _____ Email Address: _____
Message ok? ❒ Yes ❒ No

Work: _____
Message ok? ❒ Yes ❒ No

Cell: _____
Message ok? ❒ Yes ❒ No

Best method and time to contact: _____

Who to ask for when calling and relationship to client: _____

ADDRESS:

Street: _____

_____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Type of setting: ❒ Home ❒ Group Home ❒ Foster Home ❒ Psychiatric hospital

❒ R T F ❒ Other _____

Referral Reason: HEALING HEARTS

Reason for referral for Healing Hearts Program: HEALING HEARTS (who in the child's life has been impacted with or by Cancer): Please describe..
What do you hope is gained from the program: (outcomes, successful completion, feel better, etc.)

Parent or Legal Guardian Information:

Name of Parent or Legal Guardian:	
Address:	Phone:
Name of Parent or Legal Guardian:	
Address:	Phone:

ChildMental Health Information (If applicable):

Medication (if applicable) current medication & dosage:
Prescribing Physician Name:
Counseling Services (if applicable)

Current Mental Health Symptoms:	**Unknown**	**Not Present**	**Mild**	**Moderate**	**Severe**
Anxiety / Nervousness					
Obsessive / compulsive					
Phobias / fears					
Depressed mood					
Mood swings					
Sleep disturbance					
Irritability					
Anger / temper tantrums					
Hyperactivity					
Attention deficit					
Eating problems					
Elimination problems					
Oppositional / defiant to those in authority					
Antisocial / delinquent behavior / conduct disorder					
Over sexualized behavior					
Somatic complaints with no known medical cause					
Attachment disorder (explain below)					
Other (explain)					

Signature: _____ **Date** _____