PCIT CLIENT REFERRAL AND ASSESSMENT

PHILLIPS Programs for Children and Families
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Please return form to: ***FamilyPartners.Referrals@phillipsprograms.org***

Date of Referral: _____

REFERRING AGENCY

Name of Referring Worker_____

Agency: _____ County: _____

Phone Number_____ Email: _____

Is the case Medicaid? Yes _____ No _____ If yes, please give Medicaid #:_____

Has CSA funding been approved: Yes _____ No_____

If yes, how many hours of PCIT have been approved? _____

IDENTIFIED CLIENT INFORMATION

Name	Date of Birth	Age

Gender at Birth: ☐ Male ☐ Female

Identifies as: ☐ Male ☐ Female ☐ Nonconforming

With whom/where is child currently living: _____

Address: _____

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

Emergency Contact Name/Phone: _____

Primary Insurance Provider: _____

List any current medical issues/concerns: _____

Current Medications: _____

List any mental health diagnosis(es): _____

List any services the client is currently receiving or has received in the past (ex. outpatient therapy, foster care, speech therapy, special education, other):

_____

Has the identified client been placed out of the home before? ☐ Yes ☐ No

If yes, please list all placements:

Name of Placement	Date/Length of Stay

PARENTS / LEGAL GUARDIANS INFORMATION

Name	Date of Birth	Relationship to Child

Marital Status of parent(s) of guardian(s): _____

Ethnicity of Family: _____

Family Religion: _____

CONTACT INFORMATION FOR PARENTS/GUADIANS

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____Work Phone Number(s): _____

Cell Phone Number(s): _____

Household Members			
Name	**Date of Birth**	**M/F**	**Relationship to Identified Client**

BACKGROUND/ASSESSMENT INFORMATION

1. Please describe the events that led up to this referral (include client's needs and the onset and duration of the presenting problem):

2. Please describe any family history that relates to present events.

3. Please list problems that you believe contribute to the situation (e.g. substance abuse, truancy, etc.).

4. Please list the strengths of the family.

7. Please explain any safety issues that may impact our work with the family (include any at-risk behavior to self or others).

8. What services/supports does the family currently receive (outpatient therapy, foster care, mental health case management, intensive in-home services, other)?:

PLEASE NOTE: PCIT services are most effective when they are consistent and family members are available to fully participate. Please indicate any scheduling constraints or periods of time that the family will not be available to participate in services.

_____ _____

(Signature of person taking/completing referral information) (Date)