Counseling Cove
3427 4th Ave 2nd floor
San Diego, CA, 92101
Phone: 619.525.9903
Fax: 619.525.9908
Website: www.sdyouthservices.org

Referral Form

SAN DIEGO YOUTH SERVICES
Building futures for at-risk youth

Please fax completed form to our clinic at the number listed above (no cover sheet necessary). If you have any questions about our services, please refer to our brochure or contact our clinic.

Potential Clients Info

Legal Last Name	Legal First	Legal Middle	Sex	Preferred Language

Address	Phone Number(s)	Ok to leave VM?

Social Security #	Date of Birth	Ethnicity	Email Address

Please select applicable coverage potential client has:
☐ Medi-Cal Policy ID:_____
☐ Other Coverage Name of Insurance:_____ Policy ID:_____
☐ No Coverage

Parent / Legal Guardian Info

Legal Last Name	Legal First	Preferred Language	Email Address

Address ☐ Same as potential client	Relationship to Client	Phone Number(s)

Legal Last Name	Legal First	Preferred Language	Email Address

Address ☐ Same as potential client	Relationship to Client	Phone Number(s)

Referral Info and Consents

Potential client interested in receiving services? ☐Yes ☐No
Parent / legal guardian interested in participating in services? ☐Yes ☐No

Reason for referral / additional information:

Please check appropriate behavioral symptoms:
☐angry ☐argumentative ☐depressed ☐irritable ☐sad ☐anxious ☐threat to others ☐threat to self ☐self-injury
☐learning disability ☐inattentive ☐disruptive ☐declining grades ☐truancy ☐low self-esteem
☐social problems ☐withdrawn/isolates ☐health issues ☐alcohol/substance abuse ☐gang affiliated ☐runaway
☐death of a family member ☐divorce/separation ☐probation/legal issues

Referring person's Name / Organization / Phone / Email:

Date of Referral:

Potential client's signature and date:

Parent's / legal guardian's signature and date:

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY
LIVE WELL SAN DIEGO