

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



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.

<i>Potential Clients Info</i>	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: <input type="checkbox"/> Medi-Cal Policy ID: _____ <input type="checkbox"/> Other Coverage Name of Insurance: _____ Policy ID: _____ <input type="checkbox"/> No Coverage				
<i>Parent / Legal Guardian Info</i>	Legal Last Name	Legal First	Preferred Language	Email Address	
	Address <input type="checkbox"/> Same as potential client		Relationship to Client	Phone Number(s)	
	Legal Last Name	Legal First	Preferred Language	Email Address	
	Address <input type="checkbox"/> Same as potential client		Relationship to Client	Phone Number(s)	
<i>Referral Info and Consents</i>	Potential client interested in receiving services? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Parent / legal guardian interested in participating in services? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Reason for referral / additional information:				
	Please check appropriate behavioral symptoms: <input type="checkbox"/> angry <input type="checkbox"/> argumentative <input type="checkbox"/> depressed <input type="checkbox"/> irritable <input type="checkbox"/> sad <input type="checkbox"/> anxious <input type="checkbox"/> threat to others <input type="checkbox"/> threat to self <input type="checkbox"/> self-injury <input type="checkbox"/> learning disability <input type="checkbox"/> inattentive <input type="checkbox"/> disruptive <input type="checkbox"/> declining grades <input type="checkbox"/> truancy <input type="checkbox"/> low self-esteem <input type="checkbox"/> social problems <input type="checkbox"/> withdrawn/isolates <input type="checkbox"/> health issues <input type="checkbox"/> alcohol/substance abuse <input type="checkbox"/> gang affiliated <input type="checkbox"/> runaway <input type="checkbox"/> death of a family member <input type="checkbox"/> divorce/separation <input type="checkbox"/> 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:					

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