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| Date of Referral: |

**CTSS Skills Training Referral Form**

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| Client Name:       Date of Birth: |
| Ethnicity:  Latino Caucasian  African American Native American Asian American  Other |
| Parent/Guardian Name(s): |
| Address: |
| Phone number: |

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| Referral Source:       Relationship to Client: |
| Agency: |
| Address: |
| Phone number:       Fax Number: |

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| Insurance Company: |
| Primary Policy Holder: |
| Group Number: |
| Policy/ ID Number: |

**What behavioral concerns will CTSS services address?**

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| --- | --- | --- |
| Aggression | Eating/food issues | Social skills |
| Anger Management | Hygiene | Tantrums |
| Anxiety-Related Behaviors | Hyperactivity | Other (Please describe) |
| Attention | Isolation |
| Compulsive behavior | Self-harm/self-injury |

**Where are the target behaviors present?**

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| Home  School  Other: |
| For home-based services, what is the family’s availability? (Days of the week, earliest time available, etc…) |
| For school-based services, what school does the child attend? |

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| Is the child currently receiving therapy?  Yes  No  Name of therapist:       Agency:       Phone Number:  \*\*If the child is receiving therapy, please include the current diagnostic assessment. |
| Other current social/psychological services: |

**Release of information included?**

\*\*Please note that external referrals will not be accepted without a release of information.

**Please fax referral form and releases of information to:**

**Fax: (612) 871-1058 Attn: Raúl Fernandez**