Children and Family Treatment Support Services Referral Form

Date:_____

Child/Youth's Information:

Name: _____DOB: _____

Parent/Guardian Name(s): _____

Gender: _____ Phone Number: _____

Medicaid CIN and/or SSN: _____ Managed Care Organization: _____

Address: _____

Best time to contact family regarding this referral: _____

Referral Contact Information:

Referring Agency or Provider: _____

Referral Contact Name: _____

Phone Number: _____

**Current providers, please attach last comprehensive assessment or treatment plan.*

Client History:

Diagnosis: _____

Presenting concerns: _____

_____

Goals for Treatment: _____

Current medications: _____

Currently receiving clinical therapy? If yes, provider name: _____

Other providers working with client (PCP, School, DSS, Community Based Organizations, etc.):

_____

_____

Please email referral to:

cftssprogram@chjc.org

Determination of services will be shared with the referral source contact listed above. If you have any questions, please call Elizabeth Zeigler at (315) 777 -9642.