COMMUNITY HEALTH SERVICES REFERRAL FORM

"To enable all young people, especially those who need us most, to reach their full potential as productive, caring, responsible citizens."

A) INFORMATION

Referring Person/Title:	Agency:	Date:
Work Phone:	Fax:	Email:

If the child or family is in a current crisis situation -> STOP and assist. Please make sure child/family are safe before sending referral. *If child/family are safe, continue with referral.*

Client Name:	DOB:	Identified Race/Ethnicity:	Identified Gender:

School: ☐ N/A	District:	Grade:
Address:	City:	Zip Code:
Preferred Phone: ☐ Okay to text ☐ Okay to LVM	Best time to call:	Language:

B) IF CLIENT A MINOR

Guardian Name:	Relationship:	Date of Birth of Guardian:

C) SERVICES REQUESTED

Basic Needs	Mental Health/Diversion	Academic/Educational
☐ Clothing	☐ Individual Counseling *(5 y/o – 21y/o)*	☐ Child Care
☐ Food	☐ Individual Counseling *(22 y/o & up)*	☐ GED
☐ Hygiene	☐ Family Counseling	☐ General Parenting Classes
☐ Housing Resources	☐ Alcohol, Marijuana, & Other Drugs	☐ School Enrollment
☐ Insurance	☐ Anger Management	☐ Truancy Focused Parenting Classes
☐ Medical	☐ Character Building	
	☐ Juvenile Offender Education	

Reason for Referral/Presenting Concerns (Please provide as much details as possible):

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D) AUTHORIZATION

Parent/Guardian or Responsible Person's Authorization: I hereby consent to an exchange of confidential information between BOYS & GIRLS CLUBS OF GARDEN GROVE and appropriate agencies concerning my child/self in order to enhance the treatment and follow-up of the condition for which this referral is made.

Parent/Guardian Aware of referral: ☐ Yes ☐ No: Explain ____________________________________

Parent/Guardian or Responsible Person's Signature:______________________________ **Date:** ______________

CHS OFFICE USE ONLY
Date Received:

Please email or scan this referral to CHS@BGCGG.ORG – For more information regarding our programs & services, please email or visit our website at www.bgcgg.org

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