BOWLING COUNSELING CENTER
TF-CBT TREATMENT REFERRAL FORM

DATE: ______________________________

CHILD'S INFORMATION:

NAME: ____

DATE OF BIRTH: ______________________ AGE: _____________ GENDER: _______________

RACE/ETHNICITY: _____________________SSAN:_____________ MEDICAID#______________

INSURANCE #: ________________________

CAREGIVER AND SERVICE PROVIDER INFORMATION:

ADDRESS: ____

PHONE: _____________________________TYPE OF PLACEMENT: _______________________

DCBS CONTACT INFORMATION (IF INVOLVED)

DCBS WORKER: ______________________EMAIL: ___________________________________

TELEPHONE: _________________________ FAX: _____________

ADDRESS: ____

REFERRAL INFORMATION:

WHO IS PROVIDING THIS INFORMATION? ____

WHAT IS YOUR RELATIONSHIP TO THE CHILD? _______________________________________

WHAT IS THE BEST WAY TO REACH YOU? ____________________ PHONE: ________________

ADDRESS: ____

EMAIL: ____

CHILD'S HISTORY/TRAUMA HISTORY: ____

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(*CHILD'S HISTORY/TRAUMA HISTORY CONTINUED*) ____

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WHY ARE YOU REFERRING THIS CHILD FOR TRAUMA TREATMENT (TF-CBT)? _________________

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OFFICE NOTES: ____

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