Client Registration

For ALL clients not in the care and custody of their parents, Court paperwork showing guardianship must accompany this referral.

Referral Source/Name: **Referral Date**:

Agency Name (if applicable): Name: Phone: Email Address:

Supervisor: Phone: Email Address:

Community Based Care Organization (CBC) if applicable:

Client Demographic Information:

Client Name: DOB: SSN: Race: Gender: ☐ M ☐ F

Preferred Language: Insurance Name: Insurance #:

Street Address: City: Zip Code:

Name of School: Grade: Teacher:

Name of Primary Care Physician: Phone Number:

Caregiver Demographic Information *(if not parents, guardianship paperwork must accompany this referral):*

Name: Phone Number:

Placement Type:

☐ Biological Parent ☐ Relative ☐ Adoptive ☐ Non-Relative ☐ Foster Home ☐ Group Home

Briefly describe the reason for referral:

Current and/or recent risk factors (ex: Baker Act, self-injurious, aggression, arrest, substance use, elopement)**:**

Is the client currently receiving any mental health services? ☐ Yes-Where?: ______ ☐ No

Please describe:

Services Requested:

☐ **Psychiatric** (Tampa, Pinellas Park, Lakeland, Orlando Service Centers ONLY)

☐ **Mental Health Assessment**

☐ **Individual Counseling**

☐ **Therapeutic Visitation**

☐ **Family Counseling**

☐ **Targeted Case Management**

☐ **Substance Abuse** (Lakeland Service Center ONLY)

Send completed referral to: **Email: referral@familiesfirstfl.com**

or fax us by location:

***Telephone Number** (813) 290-8560 (Choose Your Service Center Accordingly)*

***Fax Numbers** ● Lakeland (863) 583-0392 ● Marianna (850) 290-7442 ●Ocala (352)354-9166*

● Orlando (407) 386-7429 ● Pinellas Park (727) 683-9849 ● Tampa (813) 354-2416 ● Tallahassee (850) 290-7442

www.familiesfirstfl.com