Children's Advocacy Center

Outside Referral Form

Please complete this form for requests for therapy services that come from outside the CAC-LMJC.

Child's Name: _____Age:_____

Services Requested By: _____

Date of Request: _____ Staff: _____

Contact Information for Requester: _____

Child's Guardian: _____

Guardian's Contact Info.: _____

Reason for Requesting Services: _____

_____

_____

Does the child qualify for services: □ Yes ☐ No ☐ Consult with Provider

If the child does not qualify for services was a referral made? □ Yes □ No

If a referral was made, where was the child referred? _____

_____

If the child qualifies for services was an Intake Appointment scheduled? □ Yes □ No

If Intake Appointment was scheduled, please provide the following details:

Date of Intake: _____ Time of Intake: _____

Provider: _____ Office: _____

Weekly appointments scheduled for: _____ Beginning: _____

Follow-up Required? □ Yes □ No