FFAST Program Referral for Services – (Handwritten version) 2017
Fax to 858-737-6972 OR Encrypted Email ONLY to apope@centerforchildren.org

SAN DIEGO CENTER FOR CHILDREN

Youth's Name:			**Date:**	
Gender:	**Age:**	**DOB:**	**Ethnicity/Race:**	**SSN:**
FFA:			**FFA Social Worker:**	
FFA Social Worker Phone #:			**FFA Social Worker Fax #:**	

Placement through: ☐Child Welfare ☐ Regional Center ☐ Probation ☐ Adoption ☐ Voluntary

Services Requested (mark all that apply): ☐Individual/Family Therapy ☐Psychiatry/Med Monitoring ☐Psychiatry ONLY (requires approval)

Language Preference: ☐ English ☐ Spanish ☐ Other:

Medi-Cal #:	**Other Health Insurance:**

Therapist Preference (personality, gender, etc.):

Referral Timeframe: ☐ Regular (5 days or less) ☐ Urgent (3 days or less) ☐ Emergency (24 hours)

Rationale if Urgent/Emergent:

Reason for Referral: _____

_____

_____

_____

Foster Parent's Name(s):	**Placement Date into Home:**	
Home/Cell Phone(s):	**Work Phone(s):**	
Street Address:	**City:**	**ZIP:**

Has the FFAST program served another child in this home? ☐ YES ☐ NO **If yes, who:**

Family therapy needed for Reunification? ☐ YES ☐ NO	**Family therapy needed for adoption?** ☐ YES ☐ NO
Bio Parent's Name:	**Bio Parent's Phone #:**
Bio Parent's Name:	**Bio Parent's Phone #:**

Bio Family Involvement:

Current DSM Diagnoses:

Dangerous Propensities:

Current Medications:

Current Psychiatrist:	**Psychiatrist Phone #:**
Current Pediatrician:	**Pediatrician Phone #:**

Date of Last Physical:

Chronic Medical Conditions and/or Allergies:

Alcohol/Drug Concerns:

Current School/Daycare:	**Grade:**	**IEP:** ☐ YES ☐ NO

Current School/Daycare Schedule:

Youth's Strengths:

Additional Supports Involved:

County Worker:	Phone:	Fax:
Regional Center:	Phone:	Fax:
CASA/Mentor:	Phone:	Fax:
Other (name/role):	Phone:	Fax:
Other (name/role):	Phone:	Fax: