San Diego Center for Children- Foster Family Agency Stabilization & Treatment (FFAST) Program
REFERRAL FOR SERVICES FORM

*Fax this form & relative documents to 858-737-6972 **OR** submit via **Encrypted Email ONLY** to ffast_referrals@centerforchildren.org*

Date of Referral: _____ **Youth's Name:** _____

Gender: ☐Male ☐Female ☐Other Ethnicity/Race: Age:

DOB: _____ SSN: ___-___-_____ Medi-Cal # *(REQUIRED to process referral)*: _____

Other Health Insurance *(Carrier & ID #)*: _____

FFA Name: _____ **FFA Social Worker:** _____

FFA SW Email: _____ FFA SW Phone: _____ FFA SW Fax: _____

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

Services Requested *(mark all that apply)*: ☐Individual/Family Therapy ☐Psychiatry/Medication Monitoring

Reason for Referral: _____

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

Rationale if Urgent/Emergent: _____

Language Preference: ☐English ☐Spanish ☐Other: _____

Therapist Preference *(gender, personality, etc.)*: _____

Current Foster Parent/s: _____ Date Placed into Home: _____

Home/Cell Phone/s: _____ Work Phone/s: _____

Address *(Street/Apt. #, City, Zip)*: _____

Has the FFAST Program served another child in this home? ☐Yes ☐No If yes, who: _____

Date Entered Foster Care System: _____

Previous Out of Home Placements: ☐Yes ☐No If yes, how many: _____

Family therapy needed for reunification? ☐Yes ☐No Family therapy needed for adoption? ☐Yes ☐No

Bio Parent Name: _____ Phone #: _____

Bio Parent Name: _____ Phone #: _____

Bio Family Involvement *(visits, no involvement, etc.)*: _____

Current DSM Diagnoses: _____

Dangerous Propensities: _____

Current Medications: _____

Current Psychiatrist: _____ Phone #: _____

Current Pediatrician: _____ Phone #: _____ Last Physical Date: _____

Chronic Medical Conditions and/or Allergies: _____

Alcohol/Drug Concerns: ☐Yes ☐No

Current School/Daycare Name: _____ Grade: _____ IEP: ☐Yes ☐No

Current School/Daycare Schedule *(weekdays & hours)*: _____

Youth's Strengths: _____

Additional Supports Involved

Regional Center: ☐Yes ☐No Ph: _____ Fx: _____

County Worker: _____ Email: _____ Ph: _____ Fx: _____

CASA/Mentor: _____ Email: _____ Ph: _____ Fx: _____

Others *(Identify Name & Role - ILS Worker, DSEP Evaluator, Mentor, etc.)*:

_____ Email: _____ Ph: _____ Fx: _____

_____ Email: _____ Ph: _____ Fx: _____

Indicate included attachments: ☐ Medi-Cal Card ☐Needs & Services Plan ☐Recent CFT Notes ☐JV-220 ☐0424

☐Other *(list all)*: _____