UPAC Multicultural Community Counseling – Referral Form

8745 Aero Drive, Suite 330, San Diego, CA, 92123
Phone: (619) 578-2211; Fax (619) 578-2245

Referring Party Name:_____ Phone Number: _____

Agency Name: _____

CLIENT INFORMATION

Date: _____ Name: _____

DOB: _____ Age: _____ Gender: ☐ M ☐ F ☐ Other

Social Security #: _____

Insurance: ☐ Medi-Cal #: _____ or ☐ No Insurance

Ethnic Background: _____ Language: _____

School: _____ Grade: _____

Home Address: _____

Received Services Before? ☐ Y ☐ N If yes, where and when: _____

CAREGIVER INFORMATION

Name: _____ Relationship: _____

Contact Phone #: _____ ☐ Home ☐ Cell Language: _____

PRESENTING CONCERNS

- ☐ Family Conflict
- ☐ * Abuse (physical, emotional, sexual)
- ☐ Neglect
- ☐ Loss/Death/Separation
- ☐ Gang Affiliated
- ☐ Legal/Juvenile Justice/CPS
- ☐ Homeless
- ☐ Alcohol/Substance Abuse
- ☐ ♦Suicidal
- ☐ ♦Making Threats
- ☐ Unusual Behavior
- ☐ Physical/Health Problems
- ☐ Anxiety
- ☐ Depressive/Moody/Withdrawn
- ☐ Eating Disorders
- ☐ Inappropriate Sexual Behavior
- ☐ Grades
- ☐ School Attendance
- ☐ Disruptive
- ☐ Hyperactive/Inattentive
- ☐ Aggressive
- ☐ Social Problems
- ☐ * Witness traumatic event

Other: _____

Additional Comments:

For Office Use: **URGENT**

Assigned to: Date:

Referral Closed
Reason: Date: