Families First of Florida
a provider of children's mental health services

Referral for Outpatient Services

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:

Fax Numbers ● Lakeland (863) 583-0392 ● Marianna (850) 290-7442

●Ocala (352)354-9166 ● Orlando (407) 386-7429 ● Tampa (813) 435-2033

www.familiesfirstfl.com