REFERRAL REQUEST FORM

Att. Admissions Coordinator
Telephone: 321-236-1540
Fax: 321-594-6096
Email: Referral@SCARFFL.com

Thank you for this referral. For assistance to complete this form, please call. Otherwise, fill in all requested information below and email or fax the referral form to us. Fax to: 321-594-6096 / email to: Referral@SCARFFL.com. You will receive confirmation once this request has been processed. If this is an Urgent Request, please call us immediately at (321) 236-1540. All referrals after 4:30PM will be processed the next business day.

Priority Need and Referral Information

Routine (3 to 7 days) ☐ Urgent (24 to 72 hours) ☐ County: ____________________ Today's Date: ______________

Referring Person Information: Agency or Person: ____

Referring Contact: ________________________ ________________________ ____________________
Phone # Email Fax

Client Information

☐ Female ☐ Male Interpreter Required?: ☐ YES ☐ NO ____________________ ________-________-________
Client Language Client's Social Security #

______________________________ ______________________________ ______ ______ ______ ______
Client's First Name Last Name M.I. DOB

Client's Address: ________________________________ City/State/Zip: ________________________________

Home Phone: ____________________ Cell Phone: ____________________ Email Address: ________________________

Caretaker Name : ________________________________ Caregiver Relationship: ________________________________

Presenting Problem or Diagnosis: ____
(this section must be filled out)

Reason for Referral (may check more than one service):

☐ Targeted Case Management ☐ Counseling Services ☐ Psychiatric Medication Services ☐ Wraparound Services

☐ Anger Management Group ☐ Diversion / FIRM Case Management ☐ Parenting Classes

☐ Mental Health Evaluation ☐ Youth Sexual Abuse Prevention (YSAP) ☐ Adolescent Substance Abuse Program

Other (please explain) ____

Insurance Information

☐ Medicaid-HMO ☐ PPO ☐ Self-Pay ☐ DCF ☐ CBC ☐ CAC ☐ FSPT ☐ OTHER ____________________

Name of Insurance Plan: ________________________________ Insurance ID #: ________________________________

Medical Group #: ________________________________ Insurance Phone #: ________________________________

Special Request: (For all special request, please include a signed release of information)

☐ Monthly Participation Report ☐ Certification of Completion ☐ Assessment Report Needed

See page 2 for ESM/DCF/Youth-SAP

REFERRAL

Case Guidelines

Case Status Information:
☐ Family Functioning Assessment Completed
☐ Child(ren) have been removed
☐ Family Preservation

Case Disposition Information
☐ Custody Issue
☐ Domestic Violence
☐ Legal Involvement
☐ Other: ____________________________

Child Welfare Referring Agency Information

DCF Service Center: ☐ Lake Wales ☐ Lakeland ☐ Bartow ☐ Highland/Hardee ☐ Other ___________________

Case Worker: ____________________________ Phone Number: ______________________________

Supervisor Name: ____________________________ Supervisor Email: _____________________________

Family /Placement Information

☐ Home ☐ Adoptive Family ☐ Family/ Relative Caregiver ☐ Group Home ☐ Foster Home ☐ Other

Household Size ________________ # Adults: __________ # Children: _________ DCF Case #: ________________

Household Member(s)

Name	Age	Relationship to Client

***EVALUATION**: If you are requesting an evaluation, please be specific about what incident led to the referral and what you hope to learn from the evaluation.
****SERVICE**: If this referral is for one of our specialized treatment programs (i.e. ESM or Youth-SAPP), please list what symptom(s) or concern(s) you would like to address, such as caregiver protective capacity or sexual harm by youth.

Referral Feedback – To be completed by SCARF personnel (office use only)

Date Referral Received: _____________________________ Appointment Date:___________________________________

Date Notification Sent by Email: ________________________ Name of Staff: ______________________________________

Staff Email: ____ Staff Phone Number: 321-236-1540 Ext.___________________