Triangle Family Services

3937 WESTERN BLVD, RALEIGH, NC 27606 • (919) 821-0790 x 333

Referral Information

Date of Referral:	
Referral Source (who is completing this form): ☐ Parent/Guardian ☐ DJJ ☐ DSS ☐ ABHC ☐ DA's Office ☐ Other:	
Referral Source Name/Agency:	
Referral Source Phone #:	Email:

Services Requested

☐ **Outpatient Therapy**	**Specialized Therapy:** ☐ Child Parent Psychotherapy (CPP) ☐ Trauma Focused CBT (TF-CBT) ☐ Comprehensive Trauma Informed Assessment (CTIA) ☐ Cognitive Processing Therapy (CPT) ☐ Problematic Sexual Behavior (PSB) Assessment and/or Treatment (**if PSB, please complete PSB Supplement on pages 2-4)** ☐ Medication Management (in conjunction with therapy at Triangle Family Services)
Briefly describe why you are referring client in the box:	

Client Information

Client Name:	DOB:	Age:
Where is client currently residing? (Home, PRTF, Hospital, Etc.):		
Client Address (include city and zip code):		
Client Race:	Gender:	Marital Status:
Client Insurance:	Insurance #:	If Medicaid, MCO:
Primary Language Spoken at Home:	Legal Involvement: ☐ Yes ☐ No	
If Client is a child, is client served by an Individualized Education Plan (IEP) or 504 Plan: ☐ Yes ☐ No		

Parent/Guardian Information (Please complete this section if client is a child)

Parent/Guardian Name:		
Parent/Guardian home phone:	Work/Cell:	
Parent/Guardian Address:	City:	Zip:
Caregiver's Name if different than Guardian(s):	Phone #:	
What is the child custody status (if parents are divorce or separated)?		

Other Agencies/Service Providers Involved with Client (e.g., Outpatient Therapist, Psychiatrist, etc.)

Name of Agency/Provider	Contact Name	Contact Phone #

Please fax to (919)518-9476 or email password protected referral form to nmejia@tfsnc.org

If you are referring for Problematic Sexual Behaviors, please complete the PSB Supplement on pages 2-4.

Problematic Sexual Behavior (PSB) Supplement

Complete for child clients with PSB needing therapy, psychosexual risk assessments, or court ordered evaluations. The information is required to link the client to the most appropriate service and clinician.

Check all that apply:

Does the client have any pending legal charges? ☐ Yes ☐ No

Has the client been court ordered to receive a psychosexual risk assessment? ☐ Yes ☐ No

If so, does client have PSB and needs an assessment for treatment and placement recommendations?
☐ Yes ☐ No

*****Please Note:*** We *cannot* schedule an initial appointment until all requested documentation has been received. **Include a copy of any of the following materials applicable to this case: Current and previous mental health providers, psychological examinations, IEP report, CME, etc.****

Has the client had a previous psychosexual evaluation? ☐ Yes ☐ No

When and where?

REASON FOR REFERRAL – Referral Source Report

What are the specific sexual behaviors of concern that the child has demonstrated?

When did the last incident occur?		How many incidents are known?
With whom did the child have the problematic sexual behaviors?		
Name	**Age**	**Relationship to referred youth**
Has the youth ever initiated sexual contact?	☐ Yes ☐ No	**Was coercion used?** ☐ Yes ☐ No

Does the child have additional behavioral concerns?

Continued next page

CHILD VICTIMIZATION HISTORY

Has child had a victimization experience? ☐ **Yes*** ☐ **Suspected*** ☐ **No**
*Complete below (check all that apply)

☐ Physical abuse	☐ Sexual abuse	☐ Neglect	☐ Psychological/Emotional
☐ Bullying	☐ Hate Crime	☐ School violence	☐ Kidnapping
☐ Community violence	☐ Accident	☐ War/terrorism	
☐ Witnessing intimate partner violence (IPV)/Domestic violence (DV)			
☐ Other:____			
Details:			

Has child completed a forensic interview? ☐ Yes ☐ No, but will complete ☐ No, not needed ☐ Unsure

Date forensic interview is scheduled or completed:

Where was or will the forensic interview be completed?

Concerns about child (check all that apply): ☐ No identifiable problems; child appears to be functioning well

☐ Not listening	☐ Moody/Sad	☐ Sleep problems/Nightmares	☐ Hyperactivity
☐ Self-harm	☐ Low self-esteem	☐ Anger/Aggression	☐ Bothersome memories
☐ Somatic complaints	☐ Anxiety/Fear	☐ Poor school performance	☐ Overwhelming grief
☐ Wetting/Soiling self		☐ Sexualized behavior	
☐ Problematic interactions with friends		☐ Problematic interactions with caregivers	
☐ Risk taking behaviors:			
☐ Other-Explain:			

Details:

Continued next page

Strengths of the child:

Department of Juvenile Justice (DJJ) Referrals ONLY

Please complete the following if referral is from the DJJ:

Youth's legal status ☐ Pre-adjudication ☐ Pre-sentencing ☐ Post-conviction ☐ Post-placement	
Court Counselor *(if different from referral source):*	Phone:
Original charge(s):	
Reduced charge(s):	
Date evaluation is due in court:	NC JOIN #:
*****Please include a copy of any of the following materials applicable to this case: Court Judgement or Order, Arrest Report, Witness Statement, Police Reports, Offender Statement, Victim Statement, CME, etc.***	

Please fax to (919)518-9476 or email password protected referral form to nmejia@tfsnc.org

OFFICE USE ONLY			
☐ Entered in Database	☐ Appt. Scheduled	☐ Email to PSB	☐ Added to PSB Calendar
☐ Releases Obtained	☐ Mail-out Packet	☐ Intake Packet	☐ Contact Log Printed
☐ Referral Source Contacted	Date(s) of Contact:		
☐ Requested Additional Documentation:			
☐ Received additional documentation:			
☐ N/A			