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: _____ Alternate Phone: _____

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/ Therapy ☐ Psychiatric Services ☐ Psychosocial Rehabilitation

☐ Y-SAPP ☐ CBHA ☐ Parenting Classes ☐ Family Preservation Services/ Enhanced Safety Management

☐ Mental Health Evaluation ☐ Adolescent Outpatient Substance Abuse Treatment 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/Y-SAPP

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 Y-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._____