REFERAL FORM

Sibling Support Therapy Program

Phone (321)345-3106
Fax (407) 644-7373

Email:jamaro@fl.easterseals.com

REFERRAL SOURCE INFORMATION

Referral by:_____ Date:_____

Phone: _____ Fax:_____ Email:_____

I _____(client or parents name) have provided permission for my child to be referred to the Behavioral Therapy Program, and I agree to be contacted by the designated Behavioral Therapist for my area.

Client/Parent/Guardian's signature_____ Date_____

DEMOGRAPHIC INFORMATION

Client Name:_____ Birth Date:_____ Age: _____

Sex: ☐M ☐F Race: ☐White ☐ African-American ☐ Hispanic ☐ Asian/Pacific ☐ Haitian ☐ Other

Legal status: ☐Minor in parent/guardian custody☐Minor in state custody

Parents/Caregiver's Names:_____

Address: _____

City/State:_____ Zip:_____

Home Phone:_____ Cell Phone/Other:_____

Email:_____

School/Daycare Info:_____ Grade:_____

Diagnosis/symptoms: _____

Type of Services Requested: individual/family therapy

Caregiver's primary language:_____ Bilingual needed? ☐yes ☐no Deaf/Hard of Hearing? ☐yes ☐no

OPEN SERVICES/PROVIDER CONTACT

☐ No current services

☐ Name/Agency:_____ Phone:_____

☐ Name/Agency:_____ Phone:_____

Supervisor notes:

Date Assigned: Therapist's Name:

"This program is funded in full or part by Orange County, Florida"