FIT Behavioral Therapy Program
Phone (321) 345-3106
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REFERRAL FORM

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: FIT 16 hours (includes 2 hour evaluation) and Social Skills 16 hours

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:_____

ADDITIONAL AREA OF CONCERN

_____

_____

Supervisor notes:

Date Assigned: Behavioral Therapist's Name:

Disability Navigator Sector/Zone:

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