

<p>WestCoast Children's Clinic <i>Referral for Services</i> Intake Line: 510-269-9043 Please Fax to 510-269-9031 (confidential fax) ATTN: INTAKE</p>

When we receive this information, we will fax you consent forms. We may also need to contact you for more info.

Child's name:

DOB:

Address:

SSN:

MediCal Subscriber ID:

Phone:

CWW:

Primary Caretaker:

Worker #:

Address:

Phone:

Fax:

Phone:

Primary Ethnicity:

Other Phone:

Language:

Biological Parents

Mother:

Father:

Address

Address:

Phone:

Phone:

Has contact: (Y / N)

Has contact: (Y / N)

Legal Status of Child (e.g. 300 dependent / etc.):

Who will be signing consents and authorizing treatment?

Any no-contact or supervised visit only situations?

Please cont. to p. 2

Presenting Problem and Type of Service Requested (therapy, testing, etc.):

Party Being Referred:

P. 2

Any medical history / current medications / psychiatric hospitalizations / recent crises (danger to self / other)/ or substance abuse history?

Reason for removal:

Any previous psychological or psychiatric services (where / with whom / why? / outcome):

Please fax this form with any supporting documentation you have available (psychological evaluations, etc.). Consents will be faxed to you.