Directions for Youth & Families

REFERRAL FORM

Fax: 614-294-3247

Phone: 614-294-2661

Intake@dfyf.org

CLIENT INFORMATION	**Referral Date:**
Client Name:	DOB: Age:
Client Address:	Gender: □ Male □ Female □ Other □ Transgender (FTM or MTF)
City, State & Zip:	Race/Ethnicity:
Phone (H,W,C):	SSN:
Phone (H,W,C):	Primary Language:
E-mail:	Interpreter Required: □ Guardian □ Client □ No
Preferred method of contact: □ Text □ Phone □ Email	FCCS: □ Open □ Closed
May we call/leave a VM? □ Yes □ No	School:
Is parent/guardian aware of referral? □ Yes ***Must be checked**	Grade:
Name of person with custody:	
Relationship to client:	

REFERRAL SOURCE	
Name/Agency:	Phone:
Referral Source E-mail:	

SERVICE REQUESTED (Please note our maximum length of stay is 6 months**):**	
□ Community Based	□ Priority Referral to New Program (Internal Only)
□ Office Based	□ Program Requested:

REFERRAL CONCERNS		
□ Academic/School Issues	□ Depressive/Mood Symptoms	□ Self harm or Suicidal Thoughts – ↓
□ ADHD Symptoms	□ Drug and/or Alcohol Use	**Do not submit referrals for individuals**
□ Anger Issues	□ Grief/Loss	**with Urgent/Immediate needs**
□ Anxiety Symptoms	□ Kindergarten Readiness	□ Sexual Abuse History
□ Behavior/Conduct Issues	□ Lost Loved One to Homicide	□ Witnessed DV
	□ Parenting/Pregnant	□ Other:

Additional Information (Court Involvement, Other Services, Safety concerns in home/community)

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If you or your child are experiencing a mental health emergency, please contact: Nationwide Children's Hospital (for youth) 614-722-1800 or Netcare (for adults) 614-276-2273 □ Provided Emergency Resource Information

INSURANCE INFORMATION	
Medicaid # (12 digit):	
Private Insurance:	Policy Holder:
Subscriber ID:	○ DOB:
Ins. Phone:	

FOR OFFICE USE ONLY:	
Pat ID:	EAP Provider:
Program:	EAP Phone #:
Special Requests:	EAP Authorization #:
Appt. Time/Days Available:	EAP # of Sessions:
Referral Taken By:	FA Needed: □ Yes □ No
Estimated Wait Time:	Source of Income/Payment:
Assigned Staff:	Number of Household Members:
	Monthly Gross Income: