Compass II Life Teen Behavior/ Leadership Outpatient Group – REFERRAL FORM

Please scan and return via email to ctltherapy@gmail.com

INFORM PARENTS TO ALLOW 1 WEEK FOR CONTACT TO BE MADE

REFERRAL DATE:

A) DEMOGRAPHICS-
Childs Name:

Mailing Address:

Age/DOB :

School & Grade:

Parents/Guardian Name:

Parent Phone Number(s):

Please describe parents' level of involvement:

Parents level of interest in this program/undecided/uninterested:

Probation and Probation Officer Name (if applicable):

B) PRESENTING BEHAVIORS-
Date of Diagnosis:
Diagnosis(s):
Concerned behaviors and reason for referral:

Describe any significant childhood history or trauma if any?

IQ Score if known- (Minimum is 70 to be appropriate for group):

List any additional information we should know that will be helpful for this program to maximize treatment?

C) REFERRAL SOURCE-
Probation Officer/Therapist/School Official Name:

Practice/Location:

Address :

Phone number: