**Beyond Barriers, Inc.**

**REFERRAL FORM**

**Please E-MAIL referral to *beyondbarriersfl@gmail.com***

Referral Source Agency Date

Referral Source Phone E-mail

Participant SSN DOB

Address Phone

Caregiver Phone

Insurance ID #

***Requested Services:***

[ ]  Anger Management [ ]  Batterer’s Intervention [ ]  Mental Health Assessment [ ]  Mental Health Counseling [ ]  Parenting [ ]  Substance Abuse Assessments [ ]  Substance Abuse Counseling [ ]  Substance Group

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child Name | Age | Relationship toParticipant | Removed | Date ofRemoval | County Child isCurrently Placed |
|  |  |  | [ ]  Yes [ ]  No |  |  |
|  |  |  | [ ]  Yes [ ]  No |  |  |
|  |  |  | [ ]  Yes [ ]  No |  |  |

***Participant’s Drugs of Choice:***

Current/Past:

[ ] Rx Drugs [ ] Cocaine [ ] Marijuana [ ] Heroin [ ] Alcohol [ ] Amphetamines [ ] Other

Date of last drug screen: Result: [ ] Positive [ ] Negative Substance:

***DCF History:***

Prior removals? [ ] No [ ] Yes, How many? Reason for removal:

Report Status: [ ]  Protective Services (In-home) [ ]  Protective Services (Out-of-home)

Past or present domestic violence in the home? [ ] Yes [ ] No Is perpetrator in the home? [ ] Yes [ ] No

Current criminal charges? [ ] No [ ] Yes (Explain: )

***Other Pertinent Information:***