**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 to  Participant | Removed | Date of  Removal | County Child is  Currently 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:***