Community Action Team (CAT)
Referral Form

Date: _____ Referral for: ☐ Guidance Care Center (GCC) ☐ Citrus Health Network (CHN)

Referral Agency: _____ Phone: _____

Name: _____ Title: _____

Email: _____ Fax: _____

Minimum Criteria for CAT Program Referrals (Ages 11-21. MUST have family participation)	
Does the client have a diagnosed mental health disorder?	☐ **YES** ☐ **NO**
Does the client have symptoms of a mental health or substance abuse co-occurring disorder?	☐ **YES** ☐ **NO**
Is the family (parent/guardian/caregiver) willing to participate?	☐ **YES** ☐ **NO**

Does the client present with at least ONE of the following risk factors (please check all that apply):

☐ At risk for out-of-home placement (due to repeated failures at less intensive levels of care)
☐ Two (2) or more psychiatric hospitalizations or repeated treatment failures
☐ Involvement with the Department of Juvenile Justice (DJJ)
☐ Multiple episodes involving law enforcement
☐ Poor academic performance and/or suspensions
☐ Other risk factors(Please List): _____

Child Information

Child's Name:				**DOB:**		**AGE: (11-21)**	
Address:				**Phone #:**			
City:				**State:**		**Zip :**	
School:				**Grade:**			
Race:		**Ethnicity:**		**Language:**			

Family Placement Information

Parent/Legal Guardian/Caregiver Name:			**Relationship to Client:**		
Address:		**City:**		**Zip:**	
Work Phone #:		**Phone #:**			
Emergency Contact/Relationship:		**Phone:**			

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I,_____, ☐ Client (if 18 or older)

or

I , _____ ☐ Parent /☐Guardian/☐Caregiver, of_____,

print parent/guardian/caregiver name/ print child's name

give my consent for_____to provide ☐ GCC ☐ CHN with my contact information

name of provider organization

for provision and eligibility screening for services in the Community Action Team Program.

_____ _____

Parent/Guardian/Caregiver/ Client Signature Date

_____ _____

Provider Organization Representative Date

For Provider Use only:			
Date Received:		Date Assigned:	
Date Family Called:		Intake Date:	
Therapist:		Case Manager:	