



Latino Community
Development Agency
420 SW 10th St,
Oklahoma City, OK 73109
(405) 236-0701
lcdareferrals@latinoagencyokc.org

Child Trauma & Children's Mental Health Referral Form

Child Information

Name: _____ DOB: _____ Gender: _____

SSN: _____

Caregiver Name: _____ Relationship to Child: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Where you affected by the Tornado on May 19-31, 2013? Yes No

Insurance Coverage: Medicaid/ Medicare Self-Paid
Medicaid #: _____

Preferred Language for Services: English Spanish

Referring Agency:

Contact Person: _____ Phone: _____ Email: _____

Service(s) Needed:

Children/Adolescent/ Adult Mental Health- Child Trauma

TF-CBT (Trauma Focused Cognitive Behavioral Therapy)

PCTI (Parent-Child Interaction Therapy)

Youth Counseling

Reason for Referral: _____