Latino Community Development Agency, Inc.
Latino Client Services
Main Office: 405-236-0701 Main Fax: 405.236.0737
420 SW 10th Street / Oklahoma City, OK 73109

Child Trauma & Children's Mental Health Referral Form

CHILD INFORMATION

Name:______________________ DOB: ____/____/____

Gender: _____F _____M

SSN: ______________________

Care Giver Name: ______________________ Relationship to Child: ______________________

Phone: ______________________ Email: ______________________

Address: ______________________ City: ________________ County: _________________

State: ________________ Zip Code: _________________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________

Were you affected by a tornado or other catastrophic event? Please specify and give dates:

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INSURANCE COVERAGE

_____ Medicaid/Medicare _____Self-Pay Medicaid #: ______________________

Preferred Language for Services: _____English _____Spanish

REFERRING AGENCY

Agency Name: ______________________ Contact Person: ______________________

Phone: ______________________ Email: ______________________

SERVICES NEEDED

_____ Children/Adolescent/Adult Mental Health - Child Trauma

_____ TF-CBT (Trauma Focused Cognitive Behavioral Therapy)

_____ PCIT (Parent-Child Interaction Therapy)

_____ Youth Counseling

Reason for Referral: ____

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