FORESTDALE
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Children and Family Treatment and Support Services (CFTSS) Referral Form

T: 718-263-0740 x730 **Fax: 914-639-4860** **Email: CFTSS@forestdaleinc.org**

Date of Referral: ___/_____/_____

PARTICIPANT INFORMATION

First Name: ______________________________ **Last Name:** ______________________________

Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Other

Date of Birth: _____/______/______

Child/Youth's Primary Language: ____

Address: ____
____

CAREGIVER/GUARDIAN INFORMATION

First Name: ______________________________ **Last Name:** ______________________________

Phone #: _________________ **Email:** __________________________ **Relationship to child/youth:** _________________________

Primary Language: ____

Address: ____ **Alt Phone:** ____________________

PARTICIPANT HEALTH INFORMATION

Managed Care Organization (MCO) ____

Member ID # ______________________

Medicaid #: ______________________

Pediatrician/Doctor's Name: __________________________________ **Tel:** ___________________

Pediatrician's Address: ___________________________________ **City:** _____ **Zip Code:** ________

Please list all known prescribed medications (name, dosage, regimen):

PROVIDER MAKING REFERRAL

First Name: ______________________________ **Last Name:** ______________________________

Agency Name: _____________________________ **Phone #:** _________________

Agency Address: ____________________________ **Email:** ______________________________
____

HEALTH HOME CARE MANAGER INFORMATION *(if applicable)*

First Name: ______________________________ **Last Name:** _______________________________

Phone #: _________________ **Email:** __________________________ **Agency Name:** __________________________

Address: ____

PARTICIPANT'S SCHOOL INFORMATION

School Name: ____________________________ **School Phone#:** __________________

School Address: ____ **Grade:** _____________

Date of last IEP *(if applicable)* ___/_____/______

MENTAL HEALTH/COMMUNITY SERVICES

Is child/youth engaged in mental health counseling/therapy? **YES** **NO**

Mental Health Therapist Name: __________________ **Provider Agency:** ______________________

Specialist/Additional Provider: ___________________ **Provider Agency:** ______________________

Primary Diagnosis: ______________________________________	**Secondary Diagnosis:** ____

SYMPTOMS OF CONCERN *(check all that apply & explain)*

☐ Depression	☐ Anxiety	☐ Phobia	☐ Danger to Self ☐ Suicidal Ideation(s)	☐ Self-Injury	☐ Danger to Other(s)
☐ Temper Tantrums	☐ Sleep	☐ Eating Disturbance	☐ Enuresis	☐ Encopresis	☐ Developmental Delays
☐ Hyperactivity	☐ Attention Deficits	☐ Impulsive	☐ Runaway	☐ Negative Peer Interactions	
☐ Physical Aggression ☐ Verbal Aggression	☐ Problematic Social Behavior	☐ Sexually Aggressive	☐ Sexually Inappropriate	☐ Alcohol Use ☐ Drug Use	

Any known safety concerns?

Why is child being referred for services now?

ADDITIONAL INFORMATION

For Referring individuals, please attach the following along with this form:

☐ Copy of Medicaid Card/MCO Card

☐ Evaluations (Psychosocial, Psychiatric, IEP, etc...)

☐ HIPAA from MH Clinic (if child receives Mental Health Services)

BELOW IS FOR CFTSS PROVIDER AGENCY TO COMPLETE

Date Received: ___________________________

CFTSS Supervisor Assigned: ___________________	Date Assigned: ______________________
CFTSS Provider Assigned: _____________________	Date Assigned: ______________________