FAMILY OUTREACH WORKER
CHILD/FAMILY CONCERN REFERRAL FORM

To:

Monica Iglesias, LMSW
Mental Health Specialist

From: _____

Center: _____ Date: _____

Child/Family: _____ Child DOB: _____

Contact Information: _____

Message: _____

_____

_____

_____

_____

_____

Behavioral Health: ***Please check box if child has experienced any significant event below***

- ❑ Death of a parent or close family member
- ❑ Parental Separation or Divorce *
- ❑ Parent(s) Incarcerated
- ❑ Child removed from home in past
- ❑ Child currently in foster care
- ❑ Other: _____
- ❑ Witness or victim of ***any*** form of violence
- ❑ Serious illness (child or close family member)
- ❑ New baby or step-siblings
- ❑ Death of a Pet
- ❑ Child resides with other family member
- ❑ Date of Significant event: _____

* If separated, divorced or incarcerated, is/are parent(s) in contact with child? ❑ Yes ❑ No

Please indicate any significant changes in the following areas or presenting behaviors of concern:

❑ Appetite ❑ Sleep Patterns ❑ Mood ❑ Tantrums ❑ Separation Anxiety ❑ Over-Active

❑ Toileting ❑ Nightmares ❑ Excessively Sad ❑ Other: _____

Has Child ever received counseling? ❑ Yes ❑ No Where? _____ When? _____

To be completed by Mental Health Specialist Only:

Date received: ___/___/____ MH follow-up: ___/___/____

ENTERED INTO CHILDPLUS

By: _____

Date: _____