HIBISCUS CHILDREN'S CENTER
Community Mental Health Referral

Return completed form to:
HCC Clinical Department
Phone: 772-340-5750
Fax: 772-323-2404
Email: LNovetti@hcc4kids.org

Referral Date_____ Referral Source_____ County of Residence_____

Name of Person Completing Referral: _____

Phone Number: _____

Email: _____

(Permission to contact referral source? Y N)

Client's name_____ Gender M F **DOB_____ SS#_____**

Address_____ City_____ ZIP_____

Legal Guardian's Name_____ Relationship_____

Home #_____ Work #_____ Cell #_____

Email address: _____ Ok to leave voice messages? Yes No

School_____ Grade_____ESE Y N **Primary Language_____**

Race
(Circle one)
1. White/Caucasian
2. African American/Black
3. Asian
4. American Indian/Alaskan Native
5. Native Hawaiian/Pacific Islander
6. Multi-racial

Ethnicity
(Circle one)
1. Puerto Rican
2. Mexican
3. Cuban
4. Other Hispanic
5. Haitian
6. None of the above

Insurance information Medicaid Y N **Private Pay** Y N
Is client involved in Protective Services? Yes No
CPI/ DCM name_____ Phone #_____

Is client involved in mental health services currently? Y N
If yes, which agency is providing current therapy services? _____

Check indicators of ____Sexual Abuse ____Substance Abuse____ Domestic Violence
____Physical Abuse ____ Human Trafficking ____ Trauma

*If indicators of sexual abuse are noted, please provide supporting documentation when submitting referral (i.e., police report, DCF intake report, or CPT report)

Reason for referral

_____
_____
_____
_____

Victim Compensation Information

Client was offered assistance in completing the Victim Compensation Form? Yes No
Did the client accept assistance with completing the Victim Compensation Form? Yes No
Has client been awarded Victim Compensation benefits? Yes No

Victim Compensation #_____ Victim Advocate Name and Phone #_____