LifeStream

Family Intervention Services (FIS)
Referral

REFERRAL SOURCE: _____
Agency Phone Number Date

CONSUMER NAME: _____
Last First MI

ADDRESS: _____ CITY: _____ COUNTY: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____ CELL PHONE: (_____) _____

CHILDREN'S NAMES/AGES: _____, _____, _____

REASON FOR REFERRAL: _____

DCF INVOLVEMENT: ☐YES ☐NO **If yes, attach intake**

CPI NAME: _____ PHONE: (_____) _____

AND/OR

CHS INVOLVEMENT: ☐YES ☐NO **If yes, attach case plan**

DCM NAME: _____ PHONE: (_____) _____

SUBSTANCE ABUSE? ☐YES ☐NO CURRENT? ☐YES ☐NO HISTORICAL? ☐YES ☐NO
PRIOR TREATMENT? ☐YES ☐NO

MENTAL HEALTH? ☐YES ☐NO CURRENT? ☐YES ☐NO HISTORICAL? ☐YES ☐NO
PRIOR TREATMENT ☐YES ☐NO

ABUSE OR TRAUMA? ☐YES ☐NO CURRENT? ☐YES ☐NO HISTORICAL? ☐YES ☐NO
PRIOR TREATMENT? ☐YES ☐NO

EXPLAIN ANY PRIOR TREATMENT: _____