CENTER FOR FAMILY SERVICES OF PALM BEACH COUNTY, INC

4101 Parker Avenue, West Palm Beach, FL. 33405
Telephone: 561.616.1222 / Fax 561.616.1230

REFERRAL FORM

(Please complete in full)

Date of referral: _______________ Referred by: ____

Agency Name: ________________ Phone: _______________________ Fax: _________________________

CLIENT INFORMATION

Name: __________________________________Date of Birth: ________________ [ ] Male [ ] Female

Medicaid #: ____________________________ Social Security Number: ____________________________

Address: ____

City: ___________________________________State: _______ Zip: ___________ Phone: ______________

Race: X White ☐Black ☐American Indian ☐Asian ☐Pacific Islander ☐Multi-Racial

Ethnicity: ☐Puerto Rican ☐ Mexican ☐ Cuban ☐ Haitian ☐ Other Hispanic ☐ Other

Language(s) spoken by client:____

Living Arrangements: ☐ With family ☐Licensed Home ☐ Shelter ☐Foster Care ☐ Other

Legal Guardian: (If minor)

Guardian Name:____Phone:____________________

Relationship to client:____

Address:____

City: ____State:_____________________ Zip:_______________

Client's School:____School Phone:____________________

REASON FOR REFERRAL

____

____

____

____

____

Referral can be faxed to 561.616.1230 OR emailed to cfsintake@ctrfam.org