801 South Kettle Street **Trauma Focused**

Altoona PA, 16602 **Cognitive Behavioral**

Office #: (814) 201-2751 **Therapy (TF-CBT)**

*\*Please send referrals to: Dennisha Shaw-Gonzales, LSW*

Email: dgonzales@evolutionblair.com

 Office #: (814) 201-2751 Fax #: (814) 201-2758

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| **DATE OF REFERRAL**  | **REFERRAL SOURCE** | **REFERRAL CONTACT #** |
|  |  |   |
| **MEDICAL ASSISTANCE #/ PRIMARY INSURANCE PROVIDER** |
|  |
| **CYF/JPO ASSIGNED STAFF** | **PREFERRED COMMUNICATION** | **PREFERRED CONTACT INFO** |
|  | CELL / OFFICE PHONE / EMAIL |  |
|  |
| **CYF/JPO ASSIGNED SUPERVISOR** | **PREFERRED COMMUNICATION** | **PREFERRED CONTACT INFO** |
|  | CELL / OFFICE PHONE / EMAIL |  |

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| **PRIMARY ADOLESCENT** |
| **FULL NAME** | **DOB/ AGE** | **SSN** |
|  |  |  |
| **CIRCLE ONE: MALE/ FEMALE/ OTHER** |  |
| **STREET ADDRESS** | **CITY, STATE and ZIP CODE** |
|  |  |
| **EMAIL ADDRESS** | **HOME PHONE** | **CELL PHONE** |
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| Who has legal custody of the adolescent? |  |
| Where does the adolescent currently reside? |  |

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| **REASON FOR REFERRAL- *Trauma(s) identified and symptom(s) occurring*** |
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| **ADOLESCENT & FAMILY STRENGTHS** |
|  |
| **SERVICES CURRENTLY INVOLVED IN FAMILY** |
|  |
| **MENTAL HEALTH DIAGNOSIS** |
| Explanation: |
| Medication: |
| **SCHOOL INFORMATION** |
| School attending:Current grade: |
| **FAMILY & HOUSEHOLD** |
| **Mother / Female Guardian Name** | **Relationship** | **Age** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  |
| **Father / Male Guardian Name** | **Relationship** | **Age** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  |
| **Number of siblings living in home** | **Other key supports** |
|  |  |

\*Feel free to attached additional info if necessary such as evaluations, school reports, or narrative info

Any additional info:

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