REFERRAL TO THE FAMILY IMPACT CENTER

REFERRING AGENCY			
AGENCY		PHONE	
ADDRESS		EMAIL	
REFERRED BY		PHONE	DATE

RECEIVING AGENCY			
AGENCY	FIRST 5 SAN BENITO	PHONE	831-634-2046
LOCATION	351 TRES PINOS RD. STE 100-A	EMAIL	referrals@sbcfic.org

INFORMATION			
LAST NAME		FIRST NAME AND MI	
DATE OF BIRTH		GENDER	
INTERPRETER REQUIRED?		LANGUAGE REQUIRED	
CHILD'S NAME		SECOND CHILD'S NAME	
BEST TIME TO CONTACT	☐Mornings ☐ Afternoons ☐ Evenings ☐ Sunday ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday		
ADDRESS		CELL PHONE	
		HOME PHONE	
		WORK PHONE	
		EMAIL	

SERVICE REQUESTED	
REASON FOR REFERRAL	
PARENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.	
SERVICE / SPECIALTY REQUESTED	

☐Promoting First Relationships ☐Home Visiting (Perinatal) ☐Home Visiting (2mos-8yrs) ☐Court Mandated
☐Case Management (8yrs+) ☐Community Education ☐Developmental Screenings ☐Other: _____

CONSENT TO RELEASE INFORMATION Read with client / caregiver and answer any questions before obtaining signature.

The signature below serves to authorize that the client understands that the purpose of the referral and disclosure of information to the agency listed above is to ensure the safety and continuity of care among service providers seeking to serve the client. The referring agency has clearly explained the procedure of the referral to the client and has listed the exact information that is to be disclosed. By signing this form, the client authorizes this exchange of information.

PARENT SIGNATURE		DATE	

OTHER COMMENTS