Bluebonnet Trails Community Services

PADRES - PARENTING AWARENESS DRUG RISK EDUCATION SERVICES

REFERRAL FORM

Client information

Name: DOB

Address:

City/State/Zip code:

Email:

Phone: Alternate phone:

CPS Status: ☐ Investigations ☐ Family-Based Safety Services ☐ Conservatorship

☐ Current case ☐ Past case

Referring Agency Information:

Name:

Address:

Staff Name & Position:

Email:

Office phone: Alternate phone:

Reason for referral:

Referral goal:

Client is: ☐ Expectant father ☐ Expectant mother

☐ Current father ☐ Current/post-partum mother

Youngest child's DOB: If expecting, how many weeks pregnant?

Consent to share information:

I, agree to allow

to **share and receive** information regarding my referral to Bluebonnet Trails Community Services.

Client signature Date

Referring staff signature Date

Notes from BTCS only: