Epworth
Empower. Every Day.

7520 Natural Bridge Road. Louis, MO 63121
Intake Coordinator# 314-541-3509 or 314-707-6337

REFERRAL FORM

Parent/Guardian Name: **Birth date:** **Race*:** **FSN Client ID #:**

Ethnicity:** **Gender:** **County of Residence:**

Address: **ZIP:**

☐ St. Louis City ☐ St. Louis County ☐ St. Charles County ☐ St. Charles City ☐ O' Fallon

Home Phone: **Cell/Other Phone:** **Client Email:**

Household Income: *This information is gathered solely to meet agency funder requirements and does not affect service eligibility or delivery.*
Please check the range that best represents current household income.

___ $0-9,999 ___ $10,000-14,999 ___ $15,000-19,999 ___ $20,000-29,999 ___ $30-49,999 ___ $50,000-59,999 ___ $60,000-99,999 ___ $100,000 or more

Medicaid # **Current/Former Epworth client/student?** ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ **Communication Assistance Required?**

Days / Times available: **School District:**

Children / Others in household:

Name	Relationship (to above)	Birthdate	Gender	Race*	Ethnicity	FSN ID #

FAMILY HAS CONSENTED TO TELEHEALTH SERVICES -- YES ☐ NO

Briefly describe current situation:

*Race: Asian, Bi-Racial or Multi-Racial, Black or African American, Native American or Alaska Native, Native Hawaiian or Other Pacific Islander, White or Caucasian, Decline to Disclose
**Ethnicity: Afghani, Albanian, Arab Bosnian, Congolese, Croatian, Hispanic/Latino, Iraqi, Roma, Serbian, Somali, Syrian, Vietnamese

Please indicate if a household member has an Autism, Cerebral Palsy, Epilepsy, Intellectual Disability or Mental Retardation diagnosis.

Name	Diagnosis	SS#	Regional Center or City Office for DD Resources?

****Obtain CIMOR if there is one****

Please check all factors that are present at time of referral:

Child/Youth Characteristics: ___ Infant (birth-1) ___ Young Child (1 to 4) ___ Child with Behavior Problems

___ Child w/ MR/Disability/Chronic Illness ___ Child with Trauma History ___ Child w/ Mental Illness

Parent Characteristics: ___ Teen Parent ___ Single Parent ___ Parent w/ History of Trauma/Domestic Violence

___ Parenting Skills or Challenges w/Discipline ___ Parent with Mental Illness ___ Parent with MR/Disability

___ Parent with history of Substance Abuse ___ Parent with present/history of Legal Involvement

___ Parent with Education Under 12 Yrs. ___ Incarceration/Probation

Family Characteristics: ___ Financial Challenges ___ Unemployment ___ Paramour in Home ___ Lack of Support System

___ Homeless or Poor Living Conditions ___ History of Hotline Calls/CD Involvement

Any safety concerns Family Therapist should know prior to visiting home? ___ Infestation ___ Unvaccinated ___ Unsafe Neighborhood ___ Weapons ___ Animals ___ Building Structural Concerns ___ Parking Concern ___ Other Concern:

Other Characteristics: _____

What other services is the family receiving? _____

Referral Source:

Agency / Organization:

Contact Number: **E-Mail:**

How have you heard about FSN? _____

REMAINDER OF FORM FOR FSN USE ONLY:

Waiting list time indicated at time of referral? _____

Resources given out, if appropriate _____

Date Referral Received: **Start-End Time:**

Intake Date:

Case #: _____ **Funder:** _____ **Total risk factors:** _____

Therapist assigned:

Date assigned: