Jewish Family & Children's Service
Healing Lives. Whatever It Takes.

Service Referral Form

Behavioral Health Services ☐ Primary Care Services ☐ Urgent ☐ Routine ☐ DCS Rapid Response ☐

Please email COMPLETED Referral to csrcteam@jfcsaz.org

Referral Agency

Today's Date: _____

Referring Agency: _____

School Code: _____

Phone Number: _____

Email Address: _____

Reason for Referral: _____

Client Information

Parent/Guardian: _____

Last Name: _____

Middle Name: _____

First Name: _____

Gender: Male ☐ Female ☐ I Identify as: _____

Date of Birth: _____

Address: _____

Telephone Number: _____

Race/Ethnicity: _____

Social Security #: _____

Interpreter Services Required: Yes ☐ No ☐ Preferred Language: English ☐ Spanish ☐ Other ☐

Preferred Pharmacy: _____

Primary Care Provider: _____

Primary Care Phone Number: _____

Primary Care Fax Number: _____

Parent/Guardian Information

If individual is under 18, Please list Parent / Guardian Information Below:

Name: _____

Address: _____

Phone: _____

Email: _____

Emergency Contact: _____

Insurance Information Optional or "If Known"

AHCCCS ID #: _____

Other Insurance Name: _____

Insurance Address: _____

ID#: _____

Services Requested

Counseling ☐ Other Behavioral Health Services ☐ Med-Management ☐ Case-Management ☐ Psych. Eval ☐

Special Instructions:

_____

_____

_____

☐ By Checking Box – "I, as a school staff member, have discussed my concerns with the Parents/Guardian and verbal Permission was given to make this referral."

Staff Signature: _____ Date: _____

Print Name: _____