

## Health Care Agency Adolescent Family Life Program

## **REFERRAL FORM**

I give my permission to be referred to the	Adolescent Family	y Life Program	(AFLP). (Op	otional)	
Signature:		Date:			
Please	complete all known	information			
Name:	DOB:	A	ge:	Sex: M	F
Address:		City:		Zip:	
Telephone # :	O.K. to call? Y	N Cell Phone	e:		
E-Mail:	Languag	e Preference:			<del> </del>
Is client currently pregnant? Y N If y	es, EDC:		Prenatal (	Care? Y	N
Name(s) of Client's Child(ren): 1.			DOB: _		
2			DOB: _		
Check all the risk factors that apply: □ domes	stic violence ☐ fo	oster child	probation	□ sexual a	assault
□ physical abuse □ substance abuse □	☐ mental health issu	es 🗆 depres:	sion □ n	nedical proble	ems
Receiving services/resources: ☐ WIC ☐ N ☐ Attending scl Additional comments or risk factors:	hool □ other				
Person Making Referral:		email:			
Agency:	Title:			Date:	
Address:		Telephone	#:		
Thanks for your referral Sant	5 W. 17 <sup>th</sup> St. ta Ana, CA 92706			none #: (714) FAX #: (714) r-County Mai	834-8051
	FOR OFFICE USE O	NLY			
Assigned for PRS to:	Referral	Taken by:		Date:	
Received by:Date:	Ref ltr #1	l date:	Ref Iti	*#2 date:	
PRS Score:Date:	Respons	se to Referent:	Da	te:	
Reassignment:		letter sent date:			
Closed date/initials:		Comments:			
Reason: UC RS OOJ AGE	NE				