



WOODLAKE FAMILY RESOURCE CENTER REFERRAL FORM

Phone 559-564-5212 Fax 559-564-5301

Date _____ Pregnant: Yes No EDD: _____
 Edinburgh Administered: Yes No Score _____
 Person being referred: _____ DOB: _____ Medi-Cal Uninsured Private Ins.
 Parent/Guardian Name(s): _____
 Parent/Guardian Address: _____
 Telephone Number (home): _____ Work: _____ Message: _____
 Primary home language: _____ Family notified of referral: Yes No

Children's Name	DOB	Children's Name	DOB

Referred by: _____ Title: _____ Phone: _____
 Email: _____

Reason for referral		
Custody/Visitation/Divorce/TRO	Substance abuse	Tulare County Victim Services
Rent/Utilities/Housing	Nutrition	Food/Clothing
Parenting	School Behavior issues/attendance	Employment
Pregnancy (teen/adult)	Medical/Dental care	Immigration
Mental Health	Medi-cal/Healthy Families	Other:

Referral Comments: _____

What intervention(s) have been tried? _____

Agency Involved: _____ Agency contact person: _____ Phone _____

Mark prior or current service involvement:		
IEP	Probation	Sequoia Youth Services
Speech Therapist	Woodlake Police Department	Tulare Youth Services
School Psychologist	Child Welfare Services	PCIT
Migrant Education	CA Children's Services	Mobile Unit
School Counselor	Central Valley Regional Services	Domestic Violence
SARB	Turning Point	Other:

Completed by (staff name): _____

<input type="checkbox"/> Immediate	<input type="checkbox"/> 5-day	<input type="checkbox"/> 10-day	<input type="checkbox"/> Previously case managed/Case #
Referral outcome:	<input type="checkbox"/> Community Referral	<input type="checkbox"/> Differential Response Pre	<input type="checkbox"/> Differential Response Post
	<input type="checkbox"/> IHEP	<input type="checkbox"/> SafeCare	<input type="checkbox"/> Tulare County Victims Services
			<input type="checkbox"/> First5
			<input type="checkbox"/> Other:
Assigned to:	Date assigned:	Date of initial contact:	Letter mailed: