



REFERRAL FORM
TULARE YOUTH SERVICE BUREAU, INC.
327 S. "K" Street, Tulare CA 93274
Phone: 688-2043 Fax: 688-1304

Date of Referral _____

Referring Party Name: _____

Referring Party Relationship or Agency Name: _____

Phone: _____ Fax/Email: _____

Name of Consumer: _____ Male ☐ Female ☐

DOB: _____ Age: _____ Grade: _____ School: _____

SS#: _____ Parent/Guardian: _____
(mandatory)

Address: _____ Phone: _____

Parent Primary Lang: _____ Contacted: Yes ☐ No ☐ Date: _____

Ethnicity: Caucasian ☐ Hispanic ☐ African Am. ☐ S.E. Asian ☐ Other: _____

Funding: ☐ Medi-Cal/Tulare Co. ☐ Medi-Cal/Other Co.
☐ Insurance Co.
☐ No Insurance/No Medi-Cal
☐ Other Funding

(Attach a copy of Medi-Cal Card or Insurance Card if available)

Dr: _____ Medications: _____

Reason for Referral/Concerns: _____

Social Worker/Probation Officer: _____ Phone: _____

Previous Counseling: ☐ No ☐ Yes Where/Who: _____

Print Form and fax to: 688-2043

E-mail To: ramona@tysb.org

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