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