The Chicago School
FORENSIC CENTER

www.thechicagoschool.edu/forensiccenter
312.467.2535

For Office Use Only			
Entered Date:			
Assigned Date:			
Clinician			
Existing Client: No	Clinician:		

COMPLETED BY:_____

Special Notes: _____

AGENCY INFORMATION

Date Form Submitted _____/_____/_____	Referring Party Name		Referring Party Title
Referring Party Phone Number (with area code)	Referring Party Email Address		Alternative Contact Person and Number (if applicable)
Agency Name	Agency Address		Fax #
Client/Recipient Involved in DCFS No	Client/Recipient Involved in Juvenile Court No	Client/Recipient Involved in Adult Court No	Client/Recipient Served by Community Mental Health No

REFERRAL CLIENT OR RECIPIENT INFORMATION

Client/Recipient Full Name			SSN
Date of Birth	Gender	Primary Language	Medicaid #
Address		City	State / Zip Code
Home Number (with area code)		Alternative Number (with area code)	Emergency Number (with area code)
Parent/Guardian Name (if applicable)		Parent/Guardian Primary Language	Parent Guardian Number (if different than client)
Parent/Guardian Address (if different than client)		City	State / Zip Code
Referring Party's Last Contact with Client/Recipient Month/Year		Client/Recipient Aware of Referral: No	Parent/Guardian Aware of Referral: (If applicable) N/A

TYPE OF SERVICE(S) REQUESTED

Treatment

Service (indicate with a check)

___Therapy (Select one): ___Individual ___Family ___Couple ___Group

Specialized Services (indicate with a check)

___Parent Child Interaction Therapy
___High Risk Parent Training
___Domestic Violence
___Job Readiness Training
___Divorce/Custody Treatment
___Mediation
___Therapeutic Supervised Visitation
___Anger Management
___Trauma (TF-CBT) /Emotional Wellness
___ Co-Parenting
___Guided Self Change (Substance abuse, recidivism)

___Other type of service requested (please explain):_____
_____

Evaluation / Screening

Service (indicate with a check)

___Fitness Restoration
30-Day Report Due Date _____/_____/_____
*90-Day Report Due Date*_____/_____/_____

___Psychological Evaluation
Please explain the nature of the request and presenting issue (i.e., cognitive/academic achievement concerns, specific gender issues, risk assessment):
Estimated Report Due Date _____/_____/_____
Records Available for Review: No or Yes
Expert Testimony Required: No or Yes (estimated date) ____/____/____

Notes: _____
_____
_____
_____

- Please fax the completed Fact Sheet/Referral Form to (312) 661-1272 to the attention of: REFERRAL COORDINATOR. Referral do not guarantee services
- Fax signed release of information and consent to mental health forms for court ordered or court involved referrals (i.e., DCFS) to expedite communication and the determination of appropriate services.
- If applicable, fax relevant statue(s) and/or guidelines for forensic oriented evaluation referrals to determine appropriate services and course of action.

SUBMIT

*Office Use Only: Payment Structure:*_____ *CTA: Yes* ☐ *No* ☐ *Update:*_____

Revised 10/31/2016