Referral/Intake Form

Please e-mail this form to: mary@projectkinship.org

PROJECT KINSHIP | 1535 E. 17th Street, #102. Santa Ana, CA 92705 | Ph: 714-941-8009 |

CONFIDENTIAL INFORMATION

Referring Person/Title:	Agency/Dept:	Email:
Phone:	Fax:	Date:

PARTICIPANT INFORMATION		
Name:	Gender:	Sex:
Address:	Phone:	DOB:
	Ethnicity:	Language:

PARENT/CAREGIVER INFORMATION		
Name:		Relationship:
Address:	Phone:	Language:

REASONS FOR REFERRAL

☐ Yes ☐ No Does this case need a bilingual worker? If yes, specify language:

☐ Yes ☐ No Does Project Kinship staff need to talk with referring person prior to intake?

☐ Yes ☐ No Has Participant been notified that a Project Kinship staff will contact him/her?

☐ Yes ☐ No OK to leave messages?

SERVICE AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

The referring party has explained to me the purpose for this referral and I agree to have a copy of this referral password protected or to take a copy of the referral to Project Kinship. I agree to attend any scheduled appointments with the Program.

I authorize the release of information between _____(referring agency) and Project Kinship for the period this service agreement remains in effect. This information will pertain to the reasons for referral and will be used for assessment and intake of the participant(s) to be served. *This referral was explained to me in my primary language.*

Participant Signature Date Referring Person Signature Date

For Office Use Only

Assigned Intake Staff Date

Director Signature Date

This Page For Office Use Only

Presenting Issue - What brings participant into program?

Onset:

Duration:

Other Possible Areas of Concern

☐ SI/HI ☐ Substance Use ☐ Gang Involvement ☐ Health Needs ☐ Medication Needs
☐ Mental Health Needs ☐ Homeless ☐ Clothing ☐ Food ☐ Childcare
☐ Pregnancy ☐ Employment ☐ Educational ☐ Financial ☐ Right to Work Docs
☐ Social ☐ Legal ☐ Spiritual ☐ Other

Describe:

Observations: check if noteworthy

☐ General Appearance ☐ Mood ☐ Affect ☐ Speech ☐ Motor Activity
☐ Thought Process ☐ Insight ☐ Judgment ☐ General Level of Functioning

Describe:

Organizations/Agencies Affiliated With

☐ Probation/Parole/Gang Terms ☐ Social Services ☐ Wraparound ☐ School Services ☐ HCA
☐ Medical Insurance ☐ Other

Describe:

Disposition

☐ Assigned Staff: _____ Date: _____
☐ Director Signature: _____ Date: _____
☐ Not Appropriate for Program ☐ Referred to: _____