



COMMUNITY HEALTH SERVICES REFERRAL FORM

"To enable all young people, especially those who need us most, to reach their full potential as productive, caring, responsible citizens."

Please email or scan this referral form to CHS@BGCGG.ORG

A) INFORMATION

Referring Person/Title:	Agency:	Date:
Work Phone:	Fax:	Email:
Would you like updates on this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Guardian Name:	Relationship:	Date of Birth:
Address:		
Preferred Phone:	Best time to call:	
Child Name:	Date of Birth:	
School:	Grade:	

B) SERVICES REQUESTED

<input type="checkbox"/> Basic Needs Clothing, Food, Transportation, Homeless, Medical, Vision, Hygiene Items, etc.	<input type="checkbox"/> Mental Health Counseling, Juvenile Offender Education, Alcohol, Marijuana & Other Drugs, etc.	<input type="checkbox"/> Academic/Educational Truancy Prevention, Parenting Classes, School Enrollment, GED, etc.
Reason for referral: _____ _____		

C) AUTHORIZATION

Language Preferred:
Okay to Leave a Message: <input type="checkbox"/> Yes <input type="checkbox"/> No: Explain Circle: Text Email Voicemail
Guardian aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No: Explain
Parent/Guardian or Responsible Person's Authorization: I hereby consent to an exchange of confidential information between BOYS & GIRLS CLUBS OF GARDEN GROVE and appropriate agencies concerning my child/self in order to enhance the treatment and follow-up of the condition for which this referral is made.
Parent/Guardian or Responsible Person's Signature: _____ Date: _____
*Required for ARCHES Referral

OFFICE USE ONLY

Date Received:
Referral Received By:
Termed Date:
Referred forwarded to: <input type="checkbox"/> ARCHES <input type="checkbox"/> FYOP <input type="checkbox"/> TRC

Please email or scan this referral to CHS@BGCGG.ORG – For more information regarding our programs & services, please email or