MARTHA'S PLACE CHILDREN'S CENTER REFERRAL FORM

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT

Date: _____ ☐ English Speaking ☐ Spanish Speaking ☐ Other Language

Child's Name _____ Child's SS# or Medi-Cal #

☐Male ☐Female Preterm: ☐Yes ☐No If yes, how many weeks: _____

Date of Birth _____ Age _____

Bio Mother's Information: Does Bio mother have any involvement with this child? ☐Yes ☐No

Name _____ Phone # _____Email

Address _____ City _____ Zip

Bio Father's Information: Does Bio father have any involvement with this child? ☐Yes ☐ No

Name _____Phone # _____Email

Foster Parent/Legal Guardian _____ Relationship to child
(If different from above)

Child's Address _____ City _____ ZIP

Phone Number _____ Email Address
Cell Phone Carrier

Is child a ward of the court? ☐Yes ☐No CWS Social Worker _____ Phone

Who is legal guardian and/or what is the custody arrangement? ****Please include court documents if applicable.*

If child is in foster care, please indicate reason:

Prenatal Exposure, if applicable (specify substances if known):

Required Information: (*Please include City & State)*

Hospital of Birth: _____ City, State: _____

OB MD/Clinic for Mother's Prenatal Care: _____ Bio Mother's DOB: ____

Pediatrician Name/Clinic: _____ City:_____

Previous Pediatrician Name/Clinic (if any): _____ City, State: _____

Hospitals for ER Visits/Hospitalizations: _____

Medical Specialists: _____

Referring Person: _____ **Agency or Relationship to child:** _____

Email: _____ **Phone:** _____ **Fax:** _____

Please mark or list any agencies with which the child you are referring is involved:

☐Child Welfare Services ☐Drug and Alcohol Services/POEG ☐Public Health Nurse- Name: _____
☐School/Preschool (i.e. Head Start, CDRC, Elementary): _____

☐Tri-Counties Regional Center/ Early Start Services Holder of ED Rights (Name): _____

☐Other: _____

Please Mark any of the following concerns you have about the child:

For Infants (under 1 year):

Feeding/Sleep Difficulties
☐Difficulty with eating/being fed
☐Difficulty with sleep initiation
☐Difficulty with sleep maintenance
☐Frequent spitting up

Emotional/Sensitivity
☐Easily startled
☐Anxious
☐Sensitive to touch/sound
☐Limited facial expression
☐Difficulty being soothed
☐Frequent or intense crying

Caregiver Relationship
☐Resists comfort from caregiver
☐Arches back when held
☐Turns head away from caregiver/ difficulty making eye contact

☐ Traumatic experiences:

☐ Please list any other concerns:

For children 1-5 years old:

Social
☐Little interest in playing with peers
☐Lack of eye contact with others
☐Few or no friends
☐Overly friendly with strangers
☐Clingy/doesn't separate

Emotional
☐Cries often
☐Not easily consoled
☐Anger/Irritability
☐Withdrawn
☐Anxious
☐Depressed
☐Fearful

Behavioral
☐Many Tantrums
☐Difficulty with transitions
☐Aggression
☐Hyperactivity
☐Impulsivity
☐Bedwetting
☐Difficulty with sleep
☐Developmental Delays

☐ Traumatic experiences:

☐ Please list any other concerns:

Please Fax to Martha's Place at (805) 781-4962
For questions please contact: **Katie Cohen, LMFT, Psy.D. 805-781-4960**