

Continued from front as needed,

Name and (Role)	Date of Birth	Name of Employer/School	Place a \checkmark if living in the home or specify where they live

Desired outcomes from therapy: _____

Identified Problems/Issues: _____

If there are identified safety risks in the home, please list concerns: _____

Comments on contacting the family: _____

Today's Date: _____ Directions to the home: _____

Please attach any evaluations, prior diagnoses information, or social summaries if available. **Services for CTS can begin only when authorizations are received.** Faxed copies of completed authorizations will be accepted. If you are referring a child in the custody of the State please fax along with the referral a signed *Professional Associates Consent for Treatment and Release of Information* form along with the referral. (Call to request forms, if needed).