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: _____ Date of Birth: _____ Age: _____

Child's Social Security Numbers or Medi-Cal Number: _____

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

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

Name: _____ Phone Number: _____ Email: _____

Address: _____ City: _____ Zip Code: _____

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

Name: _____ Phone Number: _____ Email: _____

Address: _____ City: _____ Zip Code: _____

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

Child's Address: _____ City: _____ Zip Code: _____
Phone Number: _____ Email Address: _____

Is the child a ward of the court? Yes □ No □
CWS Social Worker: _____ Phone Number: _____
Who is the legal guardian and/or what is the custody arrangement? *Please include court documents if applicable.*

_____
If child is in foster care, please indicate reason and date placed: _____

_____
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 Date of Birth: _____

Pediatrician Name/Clinic: _____ City, State: _____

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

Hospitals for any ER Visits/Hospitalizations: _____

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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: _____
☐ Medical Specialists: _____

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

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

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
- ☐ Depressed
- ☐ Fearful
- ☐ Developmental Delays

Emotional
- ☐ Cries often
- ☐ Not easily consoled
- ☐ Anger/Irritability
- ☐ Withdrawn
- ☐ Anxious
- ☐ Bedwetting
- ☐ Difficulty with sleep

Behavioral
- ☐ Many Tantrums
- ☐ Difficulty with transitions
- ☐ Aggression
- ☐ Hyperactivity
- ☐ Impulsivity

☐ Traumatic experiences: _____

_____

☐ Please list any other concerns: _____

_____

Please Fax to Martha's Place at (805) 781-4962. For questions please contact: **Martha's Place at 805-781-4948**