Aviva Family & Children's Services – Referral Form
3580 Wilshire Blvd., Suite 800, Los Angeles, CA 90010
213.637.5000 x3753 *phone* / 213.637.5001 *fax*

Referral Date:	Social Security #:
Medi-Cal Card #:	How did you hear about us? _____ _____

CLIENT INFORMATION

Name:	DOB (MM/DD/YY):
Gender:	Age:
Preferred Language:	Grade:
Interpreter Needed: ☐ yes ☐ no	Ethnicity:

CAREGIVER INFORMATION

Name:	Relation to Client:
Phone Number:	Preferred Language:
Address:	Interpreter Needed: ☐ yes ☐ no
City *Zip*	Legal Custody: ☐ mother ☐ father ☐ shared

Lives with: ☐ Bio Mo ☐ Bio Fa ☐ Guardian ☐ foster ☐ other Number People Living in Home:

PREFERRED LOCATION OF SRV: ☐ Office ☐ Home ☐ School PREFERRED THERAPIST: ☐ Female ☐ Male ☐ Either

PERSON REFERRING **SCHOOL INFORMATION**

Person Referring:	School:
Relation to Client:	Contact Person:
Phone Number:	Phone Number:

Address:		Address:	
City	*Zip*	*City*	*Zip*

REASON FOR REFERRAL *(please check all that apply)*

☐ Behavior Problems	☐ Emotional Problems	☐ Thinking Problems
☐ Parenting Practices Problems	☐ Abuse / Neglect	☐ Substance Use/Abuse
☐ Sexual Exploitation (CSEC)	☐ Other:_____	
☐ Defiance	☐ Risk of Failing School	☐ DCFS Involvement
☐ Verbal Aggression	☐ Physical Aggression	☐ Truancy
☐ Anxious	☐ Depressed	☐ Suicide Ideation

(Please provide a detailed description)