

**CENTRAL VALLEY REGIONAL CENTER, INC.
REFERRAL FORM**

Today's Date: _____

Please print, fill out, and return form by fax to: Fresno (559-276-4449), Visalia (559-738-5646), or Merced (209-723-2442)

Referral being sent to CVRC by: _____
Your Name Agency you represent

Your Address Your Phone

Does the person you are referring to CVRC have any family members who are our clients? Yes, No, or unknown (circle one)
If yes, please list:

The following information is regarding the person you wish to refer to CVRC. Please give us as much information as possible:

LAST NAME: _____ **FIRST NAME** _____ **MIDDLE** _____
DOB: _____

ADDRESS: _____ **HM PHONE:** _____
_____ **CELL PHONE:** _____
COUNTY: _____

Nature of Problem: (Include any diagnoses, functioning level, physical problems, seizures, and behavioral problems)

Is this person involved with the Court system? Yes or No (circle one)

Specific Request:

Current School Status/History:

Primary Physician:

Sources of Other Medical Data:

Current Medications:

Sources of Psychological Data:

Birthplace:

Sex: _____ **Social Sec. No.:** _____
Marital Status: _____ **Medical Insurance:** _____
Primary Language: _____ **If Medi-Cal, BIC#:** _____
Caretaker Language: _____ **SSA/SSI:** _____
Ethnicity: _____ **If SSI/SSA#, Suffix:** _____

Client's Legal Guardian, if other than parent:
Guardian's Address & Phone, if different than above:
If Court Dependent, CPS Worker's Name and Phone#:

FAMILY INFORMATION

MOTHER	Current Name: _____	Address: _____	Phone: _____
	Maiden Name: _____		
	DOB: _____	SOC. SEC. #: _____	
FATHER	Name: _____	Address: _____	Phone: _____
	DOB: _____		
		SOC. SEC. #: _____	

EMERGENCY CONTACT

TRANSPORTATION NEEDED?: Yes or No (circle one)

INTERPRETER NEEDED? Yes or No (circle one)