The Armstrong Center for Hope
Psychological and Spiritual Wellness for All Ages

Referral Form

Basic Demographic Information

Name:_____
DOB: _____
Gender:_____
Parent's Name:_____
Parent's Phone number:_____
Parent's Email:_____
If the parent is not the client's guardian, guardian's name:_____
Guardian's Phone Number:_____
Guardian's Email:_____
Where is the client currently residing:_____
What is the client's current legal status: _____pre-adjudicated _____post-adjudicated

Referral Source(s)

Name of the Referral Party: _____
Title:_____
Point of Contact: _____
Best phone number to be reached:_____
Email:_____

Referral question(s) (i.e., what are the questions that you want my help answering)?
_____
_____
_____

Who will be the ultimate recipient of the finished report?_____

How is the finished report going to be distributed and stored?
_____

Who will pay for this evaluation? How?_____

Does the client have a court counselor? If so, what is the name of the court counselor:_____
Best phone number and email_____

Does the client have an attorney? If so, what is the name of the attorney:_____
Best phone number and email_____

Request for Supporting Documents
Please provide the following collateral information, if available*:

- Comprehensive Clinical Assessment
- Any documentations regarding past legal involvement (e.g., any previous criminal records or probation records)
- School records (e.g., What records are available? When was the last time the client received testing at school? Does the client have past or ongoing IEP plan?)
- Any previous psychiatric hospitalization records
- Physical health (e.g., Any medical problems? Any previous hospitalization records?)
- Does the client's family have previous CPS involvement? Any records?

*Disclaimer: This information is important for ensuring the quality of the assessment as well as the timeline of its completion. Delays in getting this information could postpone the progress of the report.