Children and Family Mental Health Counseling

Referral Form

Program Eligibility Requirements:

- ☐ Age 5-21
- ☐ Broome County Resident
- ☐ Dual Diagnosis (I/DD & MH)

Child's Name _____ **DOB**_____

Address_____

_____ **County**___Broome_____

School District_____

School Name/Program_____

Parent/Guardian Name_____

Email address_____

Referred by_____

Diagnoses:

- ☐ Intellectual/Developmental Disability_____

  _____

- ☐ Mental Health Symptoms_____

  _____

Please indicate who was notified about this referral:

- ☐ Child
- ☐ Parent/Guardian
- ☐ School
- ☐ Any other service providers_____