WESLEY FAMILY SERVICES EXTERNAL REFERRAL FORM

Date of Referral: _______________

*Please send completed referral form to Central Access Department at:

(Fax) 412-347-3237 or (Email) CentralAccess.EmailFax@wfspa.org

Client/Child Information

Name:			Date of birth:
Social Security Number:			Age:
Race:	Gender:	Prior WFS client? ***Y N*** if yes, what was program?	
Current Street Address:			
City:	State:	ZIP:	County:
Court ordered to receive treatment: ***Y N***		CYF Involvement: ***Y N***	

Insurance Information

Primary Insurance:	Secondary Insurance:
Policy# or MA#:	Policy# or MA#:

Contact Information

Legal Guardian name and relation to client (if adult put "self"):	
Home phone:	Cell phone:
E-mail address:	Emergency Contact(s):
Who has Legal custody of Child?	Are there Custody Documents? **Y N** (if so please provide a copy)

Program(s) Referring to:

- ☐ ASD/MH OP Therapy
- ☐ 3-Day Diagnostic Testing (formerly known as CARES)
- ☐ Creative Arts (CA)
- ☐ Healthy Relationships (HR) Groups
- ☐ Other:_______________________________
- ☐ MH IOP (New Kensington Only)
- ☐ Parent-Child Interaction Therapy (PCIT)
- ☐ Psychological Evaluations / Written Order
- ☐ Psychiatric Evaluations/ Med Management
- ☐ Young Learners (YL) Group

Program(s) that require additional documents attached

- ☐ IBHS – Attach the Written Order recommending IBHS
- ☐ Intensive Family Coaching (IFC)-Attach the Written Order recommending IFC
  (Client cannot have ASD and must have CCBHO to receive IFC)
- ☐ Wonder Kids (WK) – Attach the Written Order recommending WK/IBHS Group Services

Location(s) Referring to:

- ☐ Bridgeville
- ☐ Monroeville
- ☐ New Kensington (Pioneer)
- ☐ Tarentum
- ☐ Washington
- ☐ Wexford
- ☐ WFS K-8 (JRB)
- ☐ WFS High School (Caste)

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Referral Source	
Name:	Agency:
Phone Number/Email:	Role:

Presenting Problem(s)/Reason for Referral: