A LIFEBRIDGE HEALTH GROUP
CENTER FOR HOPE
Advancing hope, healing and resilience

Center for Hope Mental Health Referral Date of Referral:

Please complete this form in its entirety and email to CFH_mentalhealth@lifebridgehealth.org

Referring Provider

Name:

Agency:

Phone number:

Email:

In-person Telehealth Minor Adult

Client Information

Client Name:

Date of Birth:

Legal Guardian Name (if applicable):

Phone:

Email:

Guardian Client Guardian Client

Best time to be reached:

Preferred Language: Ethnicity

Client Address:

Zip code:

Relationship of Legal Guardian to Client:

Biological Parent
Relative with Legal Status
Foster parent
Other (explain):

Reason for Referral (please include trauma):

Common Trauma Symptoms (check all that apply):

Sleep disturbances
Nightmares
Increased aggression
High irritability
Suicidal Ideation
Lack of interest in enjoyable activities
Difficulty concentrating
Homicidal Ideation
Prolonged negative thoughts/feelings
Increased Isolation
Increased need for attention
Other:

Type of Trauma Exposure (check all that apply):

Child maltreatment
Sexual abuse
Anti-trafficking &exploitation
Community violence (nonfatal shootings, etc.)
Runaway/missing youth
Homicide witness/victim survivor (date of death:)
Intimate Partner Violence (domestic violence)
Child Imagery