CCSI Referral Information

Referral Source and phone:____Date:_______________

Child's Name:_________________________________DOB: __________Age:________

In Custody of:____________________________relationship to child:_________________
Address and Phone:____
Child's School:____________________________Contact person:_____________________

What do you see as some of the priority needs or issues regarding this referral?
____
____
____
____

What specifically do you think CCSI can provide for this child and family?
____
____

Please note any barriers to services or treatment this child or family may have (e.g.: transportation, non-attendance by family or child, financial difficulties, non-compliance to specific therapeutic instruction, etc.:
____
____
____

Which of the following services does this child (or family) utilize now or in the past? Check all that apply. Please give approximate dates of service. Note provider if known.

_____ Individual Therapy____
_____ Family Therapy____
_____ Special Education____
_____ Day Treatment____
_____ DSS Case Worker____
_____ DSS Preventive Services____
_____ Foster Care____
_____ Probation____
_____ Residential Placement Facility____
_____ Family Support Services____
_____ CCSI____
_____ Other____

Please return this completed CCSI referral and the attached release to:

CCSI 7 Clayton Ave. Cortland, NY 13045