Referral for Parent Support Services (CLTS)

Referral Date:

Referring County:

Parent(s) Name:

Child's Name and DOB:

Phone Number:

Email:

Address:

Child's Diagnosis:

Other Services the Child and/or Family Receives:

Referring Provider Name and Contact Information:

Type of Referral: ☐ Group ☐ Individual ☐ Group and Individual

Has the Referral Been Discussed with the Client? ☐ Yes ☐ No

Reason for Referral:

Provider Signature: Date:

Please email completed copy to: alicia@blackbird-psychotherapy.com