

**Adoption Related Services of Pinellas
and DBA Family Enrichment Services
8800 49th Street N. Suite 212 ♦ Pinellas Park, FL 33782
(727) 657-7761**

REFERRAL FORM

DATE OF REFERRAL: _____ Gender: Male Female
Client: _____ Date of Birth: _____
Person referring client: _____ Phone Number: _____
Legal Guardian (if different from referral source): _____ Phone Number: _____
Insurance: _____ Policy number: _____
Current Caregiver(s) (with whom the child is currently living): _____
Type of Placement: Biological Parent Adoptive Relative Non-Relative Foster Other: _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail Address: _____
Preferred Method of Contact: Home Phone Cell Phone Work Phone E-mail
Prospective Adoptive Parent(s) (if prospective adoptive placement is pending): _____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-Mail Address: _____
Preferred Method of Contact: Home Phone Cell Phone Work Phone E-mail
Presenting symptoms or reason for seeking treatment: _____

Have parental rights been terminated? Yes No
Are there any current counseling services? Yes No (If yes, please call to discuss appropriateness of referral)
Have there been previous counseling services? Yes No
If yes, please list agency and dates of counseling: _____
Current medication(s): _____
Psychiatric provider and contact information: _____
Best days/times for appointments: _____

- Services interested in:
- Individual/Family Counseling (will also address other presenting issues)
 - Attachment-Focused Counseling (will also address all other presenting issues)
 - Specialized Assessment
 - Psychiatric Services
 - Other _____

**Please e-mail this form to
referrals@arsponline.org
or fax to (727) 865-5178
to make a referral for services**

For Administration use only: ARS FES