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CIHS Clinical Team Referral Form

To refer a child for family for clinical team services
(e.g. behavior specialist, social work) Please provide
the following information:

CIHS Participants Name

Participants DOB

Name of CIHS Participants Parent / Guardian

Parent / Guardian Contact Information

Primary CIHS Mentor Name

Primary CIHS Mentor Contact Info

What is the presenting problem or specific behavior that is of concern? (Please be specific)

How often does this behavior occur? (e.g. daily, weekly, specific to an activity)

Are there specific safety concerns? What are they?

If you are a res-hab supervisor, how did you hear about these behavioral issues?

Have these behaviors been discussed with the parents? (Yes / No)

Name of Person Making Referral

Relationship to CIHS Participant

Agency Name (If applicable)

Contact Information of person doing referral

Please do not forget to hit submit by email or print , at the top of this page. If mailing please mail to Orange County Department of Mental Health Attn: Heather Rajnert 30 Harriman Drive, Goshen NY