FAIRFAX - FALLS CHURCH
**Community Services Board**

# Referral Form

**CSB Entry and Referral Services**

Phone: 703-383-8500, Fax: 703-653-6688

Individual Name: ______________________ Date of Birth: ____________

Date: ______________ CSB Case Number (if known): ____________

Phone number(s): ______________________

Address: ______________________

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SSN: ______________ Gender: ☐ Male ☐ Female ☐ Transgender

Insurance Provider: ______________________ Medicaid: ☐ Yes ☐ No

Parent/Guardian Name/Relationship (if applicable): ______________________

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If individual is in school, grade and name of school: ______________________

Language(s) Spoken: ______________________

Person(s) who may provide additional information, including relationship and contact number:

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Referring Staff Name: ______________________ Phone: ____________

Referring Staff Email: ______________________ Fax: ____________

Referring Staff Agency/Unit: ______________________

Additional agencies involved with this individual, including names and contact numbers (if known):

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Court-Ordered Assessment/Treatment? (if yes, provide copy of order) ☐ Yes ☐ No

What incident precipitated this referral? ______________________

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Does individual have a history of arrests? ☐ Yes ☐ No Pending charges: ____________

Have you obtained any urine drug screens? ☐ Yes ☐ No

If yes, drug screen results: ______________________

Name of court: ______________ Presiding Judge: ____________

Date of next court hearing: ______________ Monthly reports required? ☐ Yes ☐ No

Probation Officer: ______________ Phone: ____________

Monthly reports to PO required? ☐ Yes ☐ No

**List**: Previous evaluations, assessments, or treatment services and applicable dates, including substance abuse treatment, mental health services, inpatient or outpatient programs, hospitalizations, psychiatric, developmental disabilities or school evaluations, medications):

________________________________________

________________________________________

________________________________________

Describe current symptoms or behaviors prompting this referral, including their duration:

________________________________________

________________________________________

________________________________________

List any medical issues: ______________________________

________________________________________

Medications individual is currently taking: ________________________

________________________________________

Do you have any specific recommendations (e.g., outpatient services, residential or medication services)?

________________________________________

________________________________________

What has the individual/family been told and what is their response to this referral?

________________________________________

________________________________________

Referring staff signature: ____________________ Date: ______________

**Attachments:** ☐ Authorization to Disclose or Request PHI (required) ☐ Court Order ☐ Affidavit and Petition

☐ CPS, APS, case findings, Investigations, etc. ☐ Hospital records ☐ Medication records ☐ Other evaluations

Please have the individual sign an Authorization to Disclose or Request Protected Health Information form (also available in Spanish); visit fairfaxcounty.gov/community-services-board/about/requesting-medical-record for instructions and forms.

If you are seeking a referral to day support services (partial hospitalization program, psychosocial rehabilitative services or employment services), please call Diana Metzger at 703-324-7416 to request an IRTT (Integrated Referral and Transition Team) referral form, then follow the procedures provided.

**IMPORTANT**: Instruct the individual you are referring to contact the Entry and Referral Team at 703-383-8500 to initiate the screening and assessment process.