Santa Barbara Office
1236 Chapala St.
Santa Barbara CA 93101
Tel: (805) 965-2376
Fax: (805) 963-6707

Santa Maria Office
210 E. Enos Dr. #A
Santa Maria, CA 93454
Tel: (805) 614-9160
Fax: (805)614-9363

Lompoc Office
110 South C St.
Lompoc, CA 93436
Tel: (805) 741-7460
Fax: (805) 736-6495

Request for Services:

Date of Referral: _____ **Preferred Language:**_____

Client Information:

First Name: _____ Last Name: _____

Date of Birth:_____ Gender: _____

What insurance does this person currently have? ☐ MediCal/CenCal ☐ Private Insurance ☐ Other/None

Parent/Guardian Information:

Parent/Guardian #1: _____ Relationship to Client: _____

Address (#, Street, City, and Zip) _____

Phone #: _____ Okay to leave voicemail? ☐ Yes ☐ No

Is this person currently the child's legal guardian/custodian? ☐ Yes ☐ No

Parent/Guardian #2: _____ Relationship to Client: _____

Address (if different from above) _____

Phone #: _____ Okay to leave voicemail? ☐ Yes ☐ No

Is this person currently the child's legal guardian/custodian? ☐ Yes ☐ No

Have parent(s)/guardian(s) been informed of this referral? ☐ Yes ☐ No

Other Children in the Home:

Name:	**Date of Birth:**	**Gender:**	**Services requested for this child? (Y/N):**	**Insurance (MediCal, Private, Other?)**

Referring Party Information:

Referring Party Name: _____

Agency/School: _____

Phone Number: _____ E-mail: _____

Presenting Problem:

_____

_____

_____

_____

Referring Provider Comments:

_____

_____

_____

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