945 N. Indian Creek Drive, Clarkston, GA 30021
Office (404) 298-9005 Fax (404) 298-0046
Website www.positivegrowthinc.org

CHILD AND ADOLESCENT SERVICE REQUEST FORM

*Please print and submit to **gcassady@positivegrowthinc.org** via fax or email*

Referral Date:	
Child Name:	
Date of Birth:	
Race/Ethnicity:	
Sex (male or female)	
Social Security Number:	
Guardian / Parent Name:	
Address:	
City / State / Zip:	
Home Phone Number:	
Cellular Phone Number:	
DFCS Worker / PO	
Phone Numbers (Office / Fax / Cell)	
Referral Source:	
School & Grade / Employer:	

Insurance:	❘None ❘Medicaid ❘Peachstate ❘ Wellcare ❘Amerigroup □Medicare □ Caresource
Insurance Number	

REASON FOR REFERRAL

Presenting Problems:			
Service Requesting *Check all that Apply*	❘ Individual Counseling	❘ Group Counseling/Training	❘ Family Counseling / Training
	❘ Assessments / Evaluations *Family, Substance, Anger, etc.*	❘ Family Violence Intervention Program (FVIP)	❘ Trauma Focus – Cognitive Behavior Therapy
	❘ Behavior Health Assessments and Service Plan Development	❘ Brief Crisis Stabilization ❘Nurturing Parenting Program	❘ Parent Education Class ❘ Fatherhood Education Class
INTAKE USE	❘ Community Support (CSI)	❘ Individual Outpatient Services	❘ Peer Specialist Support
CONTACT ATTEMPTS 1.________ 2.________ 3.________	❘ Psychological Evaluation ❘ Psychiatric Evaluations	❘ Anger Management Group ❘ DUI Clinical Evaluation	❘ Substance Abuse IOP ❘ Substance Abuse Education
INTAKE USE	❘ Partial Hospitalization Program	❘ Safe Care –Parenting Program	❘ Promoting Safe and Stable Families (PSSF)

Assessment Scheduled With, Day/Time:	**Individual Added to Intake Tracker:**
Assessment Complete:	**Individual Added to SN:**

last updated 8/2018