

BEXAR COUNTY COMMUNITY RESOURCE COORDINATION GROUP (CRCGF)

DATE OF REFERRAL: _____ SIGNED RELEASE CONFIRMED ___Y ___N

I. NAME OF PRESENTER: _____ **AGENCY:** _____
PHONE NUMBER: _____ **FAX#:** _____ **Email:** _____

II. CASE PRESENTER:

List agencies currently/past involved with the child/family:

III. THE CHILD: Name: _____

D.O.B. _____ Age: _____ Gender: _____ Ethnicity: _____ SSN: ____ - ____ - ____

School/District: _____ Special Education: _____ Y _____ N Grade _____

Is the child eligible for Medicaid or CHIP? _____ Is the child at-risk for out-of-home placement?

_____ Y _____ N Substance Abuse: _____ Type: _____ Gang Affiliation: _____

IV. PSYCHICAL/MENTAL HEALTH:

Current diagnosis: _____ Date of latest Eval: _____

Attending Physician: _____ Medications: _____

Mental Health services received: _____ Counseling: _____

Psychological/psychiatric evaluation by: _____

V. SOCIAL/FAMILY:

Child's current living arrangement and how long: _____

Family Information (Biological, extended, or other): _____

Who does the family contact when they need help or assistance? This may be a family member, friend or clergy. Name: _____ Phone Number: _____

Who does the child contact for help or assistance? This may be family member, friend, teacher or other.

Name: _____ Phone Number: _____ Relationship: _____

VI. REFERRAL INFORMATION:

Reason(s) referred to CRCG: _____

What is the main reason for the referral? _____

Relevant history/interventions attempted: _____

What interventions have worked for this child/family? _____

Other comments: _____

Staffing Dates: _____ **Initial** _____ **2nd Month** _____ **6th Month** _____