

South County S.A.F.E./CAPSLO Referral Form

Send Referral to:

Administrative Assistant CAPSLO

Fax: (805)541-1264

Email: southcountysafe@capslo.org



Child's Name: _____	DOB: _____	
School: _____	Grade: _____	Phone Number: _____
Parent/Guardian Name: _____	Home Language: _____	
Residential Address: _____	Does child have Medi-Cal: Yes No	
Sibling Name: _____	School: _____	DOB: _____
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Sibling Name: _____	School: _____	DOB: _____

Yes, parent/guardian was informed of referral to SAFE System of Care, which includes County Behavioral Health and CAPSLO, who may share information in order to coordinate services.

Please check service(s) you are requesting for the child/family:

- Counseling (outside of school) Family Advocate Services/Basic Needs

Reason for Referral- Please check all that apply

<input type="checkbox"/> Easily Frustrated	<input type="checkbox"/> Inattentive	<input type="checkbox"/> Sad	<input type="checkbox"/> Fearful
<input type="checkbox"/> Oppositional	<input type="checkbox"/> Disruptive Behavior	<input type="checkbox"/> Anxious	<input type="checkbox"/> Other <small>(please describe below)</small>

Major Problems or Concerns- Please check all that apply

<input type="checkbox"/> Divorce	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Blended Family	<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> Loss/Grief	<input type="checkbox"/> Parent/Child Conflict	<input type="checkbox"/> Financial Stress	<input type="checkbox"/> Homelessness
<input type="checkbox"/> Trauma	<input type="checkbox"/> Medical Needs	<input type="checkbox"/> Developmental Concerns	<input type="checkbox"/> Abuse/Neglect <small>(see below)</small>

Was child abuse/neglect reported? Yes No

Other Information (attach separate sheet, if necessary)

Referring Party Name: _____	Agency: _____	
Phone: _____	Email: _____	Date: _____