PCIT Referral Form

2050 Youth Way
Fullerton, CA 92835
(714) 871-9264 Ext. 520

6301 Beach Blvd., Suite 245
Buena Park, CA 90621
(714) 736-0231 Ext. 520

525 Cabrillo Park Dr., Suite 300
Santa Ana, CA 92701
(714) 953-4455 Ext 520

Referral Date: _____ Referred By: _____
Phone #: _____ Agency Name: _____

Should any correspondences be made with referring party BEFORE contacting client? _____

Caregiver's Name: _____ Relationship:_____

Child's Name: _____ Date of Birth: _____

Child's Insurance: _____ Other:_____

Address: _____

Home Phone: _____ Cell: _____

Primary Language Spoken: _____

Availability: _____Person Responsible for Payment: _____

REASON FOR REFERRAL:

_____

_____

_____

I, parent/guardian authorize Child Guidance Center, Inc. (CGC) to contact me in order to discuss the referral of my child for mental health services.

Parent/Guardian Signature: _____ Date: _____

Please send referrals to:
Kelly Chapman
(714) 871-9264 Ext. 520
(714) 578-0286 (Fax)
www.PCITmethod.com

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