Thank you for your interest in The Chicago School Forensic Center! Please fill out the referral form below and attach the required documentation as it applies to your request for services.

**NOTE:** *If the form is not filled out in its entirety or the required documentation is not attached, we may not be able to honor your request for services.*

Please attach the following documents as it applies to the referral:

- Court order (please ensure this is a readable copy)
- Financial Documentation:
    - If the client has Medicaid, please write the client's Medicaid Identification Number in the space provided on the referral form.
    - If the client does not have Medicaid and is looking for a sliding scale fee, please attach:
        - The two most recent income statements (pay stubs, unemployment statement, etc.)
        - Bank statements for the past 30 days
- A copy the client's photo ID

You may submit the following information in one of two ways:

- Fax: 312-628-7612
- Email: ForensicCenter@thechicagoschool.edu

If you have any questions regarding submitting a referral for services, please call 312-467-2535.

Thank you again for your interest in the Forensic Center and we look forward to working with you!

# REFERRAL FOR SERVICES

## CLIENT INFORMATION

| Client Name | Date of Birth | Date of Referral |
|---|---|---|
| | | |
| **Client's Address (Street, City, State, Zip)** | **Client's Phone** | **Client's Email** |
| | | |
| **If client is a minor, parent/guardian name (and address if different)** | **Parent's Phone (if different)** | **Parent's Email (if different)** |
| | | |

| Anticipated method of payment: | If referral is court-ordered, please provide case number and county: |
|---|---|
| ☐ Self-Pay ☐ Medicaid- Medicaid #: _____ | |

## REFERRING PARTY INFORMATION

| Referring Party Name, Title/Organization ("Self" if self-referred, and skip this section) | Referring Party Phone |
|---|---|
| | |
| **Referring Party Address (Street, City, State, Zip)** | **Referring Party Email** | **Referring Party Fax** |
| | | |

## SERVICES REQUESTED

| Therapy Services | Evaluation Services |
|---|---|
| Therapy:<br>☐ Individual ☐ Family ☐ Couples<br>Specialized Services:<br>☐ Therapeutic Supervised Visitation<br>☐ Reunification Therapy<br>☐ Parenting Skills Training<br>☐ Co-Parenting | ☐ Psychological Evaluation<br>Reason for referral (type of evaluation and issues to be addressed) **MUST BE COMPLETED**:<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |

## OTHER PARTIES INVOLVED IN SERVICES

If the services involve other parties or family members, please provide their information below:

| Other Parent/Guardian's Name | Phone Number |
|---|---|
| | |
| **Other Party's Attorney** | **Phone Number** |
| | |
| **Guardian ad Litem/Child Representative (or Party's Attorney if GAL/CR is referral party)** | **Phone Number** |
| | |
| **Children (Full Names)** | **Children's Ages** |
| | |