



CENTER FOR FAMILY SERVICES OF PALM BEACH COUNTY, INC
Strengthening families through counseling and education
 4101 Parker Avenue, West Palm Beach, FL 33405
 Telephone: 561.616.1222



Referral may be faxed to 561.616.1230 or emailed to cfsintake@ctrfam.org

REFERRAL FORM

(Please complete in full)

Date of referral: _____ Referred by: _____

Agency Name: _____ Phone: _____ Fax: _____

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Male Female

Medicaid #: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Race: White Black American Indian Asian Pacific Islander Multi-Racial

Ethnicity: Puerto Rican Mexican Cuban Haitian Other Hispanic Other: _____

Language(s) spoken by client: _____

Living Arrangements: With family Licensed Home Shelter Foster Care Other

Legal Guardian: (If minor)

Guardian Name: _____ Phone: _____

Relationship to client: _____

Address: _____

City: _____ State: _____ Zip: _____

Client's School: _____ School Phone: _____

REASON FOR REFERRAL
