FAIRFAX - FALLS CHURCH
Community Services Board

Referral Form

CSB Entry and Referral Services

Phone: 703-383-8500, Fax: 703-653-6688

Individual Name: _____ Date of Birth: _____

Date: _____ CSB Case Number (if known): _____

Phone number(s): _____

Address: _____

SSN: _____ Gender: ☐ Male ☐ Female ☐ Transgender

Insurance Provider: _____ Medicaid: ☐ Yes ☐ No

Parent/Guardian Name/Relationship (if applicable): _____

If individual is in school, grade and name of school: _____

Language(s) Spoken: _____

Person(s) who may provide additional information, including relationship and contact number:

Referring Staff Name: _____ Phone: _____

Referring Staff Email: _____ Fax: _____

Referring Staff Agency/Unit: _____

Additional agencies involved with this individual, including names and contact numbers (if known):

Court-Ordered Assessment/Treatment? (if yes, provide copy of order) ☐ Yes ☐ No

What incident precipitated this referral? _____

Does individual have a history of arrests? ☐ Yes ☐ No Pending charges: _____

Have you obtained any urine drug screens? ☐ Yes ☐ No

If yes, drug screen results: _____

Name of court: _____ Presiding Judge: _____

Date of next court hearing: _____ Monthly reports required? ☐ Yes ☐ No

Probation Officer: _____ Phone: _____

Monthly reports to PO required? ☐ Yes ☐ No

List: Previous evaluations, assessments, or treatment services and applicable dates, including substance abuse treatment, mental health services, inpatient or outpatient programs, hospitalizations, psychiatric, developmental disabilities or school evaluations, medications):

Describe current symptoms or behaviors prompting this referral, including their duration:

List any medical issues:

Medications individual is currently taking:

Do you have any specific recommendations (e.g., outpatient services, residential or medication services)?

What has the individual/family been told and what is their response to this referral?

Referring staff signature: Date:

Attachments: ☐ Authorization to Disclose or Request PHI (required) ☐ Court Order ☐ Affidavit and Petition

☐ CPS, APS, case findings, Investigations, etc. ☐ Hospital records ☐ Medication records ☐ Other evaluations

Please have the individual sign an Authorization to Disclose or Request Protected Health Information form (also available in Spanish); visit fairfaxcounty.gov/community-services-board/about/requesting-medical-record for instructions and forms.

If you are seeking a referral to day support services (partial hospitalization program, psychosocial rehabilitative services or employment services), please call Diana Metzger at 703-324-7416 to request an IRTT (Integrated Referral and Transition Team) referral form, then follow the procedures provided.

IMPORTANT: Instruct the individual you are referring to contact the Entry and Referral Team at 703-383-8500 to initiate the screening and assessment process.