SENECA
FAMILY OF AGENCIES | UNCONDITIONAL CARE

Therapeutic Case Management Referral Form

Call: 253-356-8459; Email: TCMreferrals@senecacenter.org
Or send via confidential fax: 510-830-3596

Date of Referral:	**Office Only**
Name of Referent:	INTAKE APPT DATE & TIME:
Referent Phone No.:	COUNSELOR ASSIGNED:
Referent Email:	SCHEDULED BY:
Relationship to Client:	SCHEDULED ON:

CLIENT INFORMATION

Name:	DOB:	Age:
Ethnicity:	Primary Language:	
Gender:	Pronouns:	
Child/Youth Primary Address:		
Child/Youth Phone:	Voicemails? Yes ☐ No ☐	
Primary Caregiver(s) Name/Relationship to Youth:		
Phone:	Voicemails? Yes ☐ No ☐	
Email:		
What school does the youth attend?		
Do you have primary insurance? Yes ☐ No ☐	Primary Insurance:	
Other Important Adults/Family Member(s)		
Name:	Relationship to Child/Youth:	
Name:	Relationship to Child/Youth:	

REASON FOR REFERRAL

Presenting Symptoms (please circle all that apply):

Suicidal Ideation ☐	Depressed Mood ☐	Tearful/Cries Often ☐	Hyperactive ☐
Suicide Attempt ☐	Social Withdrawal ☐	Easily Distracted ☐	Poor Impulse Control ☐
Physical Aggression ☐	Verbal Aggression ☐	Anxious ☐	Fidgety ☐
Paranoia ☐	Hypervigilant ☐	Obsessive Thoughts ☐	Compulsive Behavior ☐
Self-Mutilation ☐	Phobias ☐	Bedwetting ☐	Nightmares ☐
Hallucinations ☐	Disrupted Sleep ☐	Harmful to animals ☐	Drug Use ☐
Homicidal Ideation ☐	Weight loss/gain ☐	Poor social skills ☐	Disrupted Attachment ☐

Reasons for Referral:

What previous behavioral/ mental health services have been attemtped?

CONTACT (Check all that apply)

Best days to contact: M ☐ T ☐ W ☐ Th ☐ F ☐	Time of day: Mornings ☐ Afternoons ☐ Evening ☐