ICT CLINICAL SERVICES
(Adolescent Integrated Co-occurring Treatment)
130 W. Gabilan Street, Salinas, CA 93901
Voice (831)758-0181 Fax (831)758-5127

REFERRAL DATE_____

NAME _____ DOB _____ GENDER ☐ M ☐ F
Last First Middle (Check one)

ADDRESS _____PHONE _____
Street City Zip code

Medi-Cal # _____ Social Security # _____

MESSAGE PHONE _____ LIVING WITH _____
(Specify relationship: ex., Parent, Foster Parent, Extended family)

EMERGENCY CONTACT _____ PHONE_____

MOTHER _____ PHONE_____
Last Name First

FATHER _____ PHONE_____
Last Name First

ETHNICITY_____

PRIMARY LANGUAGE (Parent)_____

PRIMARY LANGUAGE (Client) _____

PROBATION OFFICER (If any) _____PHONE_____

THERAPIST (If any) _____PHONE_____

SCHOOL_____PHONE_____

GANG AFFILIATION (If any) _____

HAS PARENT BEEN NOTIFIED OF ICT REFERRAL (check one) ☐ YES ☐ NO

HAS CLIENT BEEN NOTIFIED OF ICT REFERRAL (check one) ☐ YES ☐ NO

Reason for Referral:

Referred by _____Agency _____Phone_____

I hereby authorize services for myself or on behalf of my minor child for ICT CLINICAL SERVICES. I give my permission to ICT CLINICAL SERVICES staff to contact the above referral source.

Signature_____ Date: _____