



Positive Parenting Program Triple P Referral Form

Fax # (805) 351-8000

Referral Date: _____

Referring Organization: _____

Elementary School: _____ Middle School: _____

Referring Person: _____ Relation to Client: _____

Phone: _____ Email: _____

Client Information:

Last Name: _____ First Name: _____ DOB: _____ M _____ F _____

Parents' Primary Language: English: _____ Spanish: _____ Other: _____

Parent/Guardian Name: _____ Relationship to client _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

Street City Zip Code

Behaviors:

Defiance _____ Non-Compliance _____ Aggression _____

Lying _____ Talking Back _____ Whining _____

Other _____

Comments _____

Has the family been notified of the Triple P referral? Yes _____ No _____

Has the family received Level 2 or 3 interventions? Yes _____ No _____

I understand that I am being referred to Interface Children & Family Services for Triple P. I hereby give my consent for the exchange and release of information for this purpose.

Authorized Signature

Date

For ICFS Staff use only:

Therapist: _____ Date of Screening/Intake: _____

PEI-7081: _____ Group: _____ Level 3 _____

First 5-7082: _____ Individual: _____ Level 4 _____

Level 5 _____

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If you have any questions, please contact the Interface Mental Health Intake Department at (805) 485-6114 Ext.684