



**REFERRAL FORM**  
**TULARE YOUTH SERVICE BUREAU, INC.**  
 327 S. "K" Street, Tulare CA 93274  
 Phone: 688-2043 Fax: 688-1304

Date of Referral \_\_\_\_\_

Referring Party Name: \_\_\_\_\_

Referring Party Relationship or Agency Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax/Email: \_\_\_\_\_

Name of Consumer: \_\_\_\_\_ Male  Female

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

SS#: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_  
 (mandatory)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent Primary Lang: \_\_\_\_\_ Contacted: Yes  No  Date: \_\_\_\_\_

Ethnicity: Caucasian  Hispanic  African Am.  S.E. Asian  Other: \_\_\_\_\_

**Funding:**  Medi-Cal/Tulare Co.  Medi-Cal/Other Co.  
 Insurance Co.  
 No Insurance/No Medi-Cal  
 Other Funding

**(Attach a copy of Medi-Cal Card or Insurance Card if available)**

Dr: \_\_\_\_\_ Medications: \_\_\_\_\_

Reason for Referral/Concerns: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Social Worker/Probation Officer: \_\_\_\_\_ Phone: \_\_\_\_\_

Previous Counseling:  No  Yes Where/Who: \_\_\_\_\_

**Print Form** and fax to:688-1304 **E-mail To:** [jjuares@tysb.org](mailto:jjuares@tysb.org)

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