Please send referrals to the Family Center

1041 Pearl Street Suite L Brockton MA 02301

Phone: 508-857-0272 Fax: 508-857-3361

Email: Brocktoncc@gmail.com

# REFERRAL FORM

**Parent/Guardian Name:** _____ **DOB:** _____/_____/_____

**Child's Name:** _____ **DOB:** _____/_____/_____

**Child's School Name:** _____

**Email Address:** _____

**Preferred Phone Number:** _____ C H

**Address:** _____

**Preferred Language:**

**English** ☐ **French** ☐ **Spanish** ☐ **Haitian Creole** ☐

**Cape Verdean Creole** ☐ **Portuguese** ☐ **Other** ☐ _____

**Referral Source:**

**Name:** _____ **Phone Number:** _____

**Parent/Guardian** ☐ **Court** ☐ **School** ☐ **Police** ☐

**Recovery Coach** ☐ **Dr/Hospital** ☐ **Other** ☐ _____

**Reason for Referral (check all that apply):**

**Habitual School Offender** ☐ **Habitual Truant** ☐ **Sexually Exploited Child** ☐ **Drug Endangered Child** ☐

**Runaway** ☐ **Stubborn Child** ☐ **Basic Needs/Hardship** ☐ **Mental Health/Substance Use** ☐

**Additional Information:**

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