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

Date: _____

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: **Signed Release** **Y** **N**