Service Area: 1 2 3 4 5 6 7
Services Preferred at: Home Office Telehealth
Minute Order/Custody Doc:
Mat SOF/CFT
Detention Report
I-CARE
Cans
Medical copy:

566 S. Brand Blvd., San Fernando, CA 91340
Referral Center Contact: 818.898.0223
Fax: 818.361. 5384
Email: referrals0-5@ecda.org

INFANT MASSAGE REFERRAL

Referral Party **Date:**

Name:______________________________. Phone:______________________ Agency/Role:______________________

Email:____________________________________ Are the client and family aware of this referral? Yes No

Client Information:

Name: __________________________ M.I: ____ Last Name: _______________ F M DOB: _____________ Age:_____________

DMH ID# __________ Race/Ethnicity: ________________ Primary Language: ________________ Soc. Security # _________________________

Medical: Y N If yes, Medi-cal # __________________________

Bio Mother's Name: ________________________ Lost Custody History of Substance use.` DV. Neglected Clt

Bio Father's Name: _______________________ Lost Custody History of Substance use. DV. Neglected Clt

Bio Parents Participating in Services? N Y If yes, who and contact information: ______________________________

Primary Caregiver

Client currently lives with: Mother Father Guardian Foster Parent Other:______________

Caregiver's Name:__________________________ Primary Language:_____________ Phone: _______________________ Leave Message: Y. N

Address:_______________________________________ City: ___________________ Zip: __________________

Email: ____________________ When can we call? Mon Tues Wed Thurs Fri Time:_____________

Clinical Information

Currently receiving any other type of services? Yes No Unknown *if yes from where/whom:*______________________

Is client currently receiving medication? Yes No Unknown *If yes what medication and frequency:* _____________________

Does Client have an open DCFS case? Yes No Unknown *if yes name and contact of CSW:*
*Phone Number:*_______________ *Email:*

Experiencing the Following:

______Developmental Concerns
______Sleeping difficulties
______First time Parents
______NICU
______Difficulty in labor/delivery
______Difficulty gaining weight
______Exposed to Substances in Utero
______Lack of Eye Contact

_____ Medical Issues
_____ Recent Surgeries
_____ Muscle Stiffness
_____Colic
_____Crying
_____Digestive Difficulties
_____Trauma
_____Exposure to DV

______Removed from Bio Parents (date:_______ ______)
______Multiple Placements
______MAT involvements
______DCFS Involvement
______ Difficulty in transitions
other concerns:

Gestation Period: _________________
Birth Weight: ______________________
Access to Prenatal care: Y N

Please elaborate on any checked above