566 S. Brand Blvd San Fernando, CA 91340 Phone: 818.898.0223. FAX: 818. 361. 5384

referrals0-5@ecda.org

INFANT MASSAGE REFERRAL

EL CENTRO DE AMISTAD
THE FRIENDSHIP CENTER

REFERRAL PARTY: PLEASE NOTE THAT ALL MAT REFERRALS WILL REQUIRE A ***MINUTE ORDER/CUSTODY DOCUMENTATION/DETENTION REPORT, I-CARE, CANS, AND MEDICAL COPY***. **THE REFERRAL WILL NOT BE PROCESSED IF DOCUMENTS ARE MISSING. Send referral with documents to referrals0-5@ecda.org**

REFERRAL PARTY INFORMATION

DATE:_____

NAME _____ AGENCY/ROLE _____

EMAIL: _____ Is the family aware of the referral ☐ Y ☐ N

PHONE NUMBER : _____ Is client a Mat Referral ☐ Y ☐ N

CLIENT INFORMATION

NAME (First & Last) _____ DOB: _____ ☐ M ☐ F

DMH ID:_____ RACE/ETHNICITY:_____ SOCIAL SECURITY: _____

MEDICAL NUMBER:_____ AGE IN MONTHS:_____

BIOLOGICAL PARENT INFORMATION

PLEASE FILL OUT IF CHILD IS CURRENTLY OUTSIDE OF THE CARE OF BIOLOGICAL PARENTS

BIO MOTHER'S NAME:_____ ☐ LOST CUSTODY ☐ DV ☐ SUBSTANCE USE ☐ NEGLECT

BIO FATHER'S NAME:_____ ☐ LOST CUSTODY ☐ DV ☐ SUBSTANCE USE ☐ NEGLECT

ARE BIO PARENTS PARTICIPATING IN SERVICES ☐ Y ☐ N IF YES PLEASE PROVIDE CONTACT INFO: _____

PRIMARY CAREGIVER

CAREGIVER TYPE: ☐ MOTHER ☐ FATHER ☐ RELATIVE/GUARDIAN ☐ FOSTER PARENT

CAREGIVER FULL NAME: _____ PHONE: _____

ADDRESS: _____ EMAIL: _____

BEST TIME TO CALL: _____ LEAVE VM OR TEXT ☐ VM ☐ TEXT

CLINICAL INFORMATION

☐ developmental concerns	☐ Exposed to substances in Utero	☐ Excessive crying/difficult to soothe	☐ Multiple Placements	☐ Limited access to prenatal care
☐ sleeping difficulties	☐ medical issues/ medical trauma	☐ Trauma	☐ difficulty in transitions	
☐ first time parents	☐ Recent Surgeries	☐ Exposure to DV/ Family Violence	☐ Attachment concerns	Gestation Period _____
☐ NICU	☐ Muscle stiffness	☐ Digestive difficulties	☐ Lack of prenatal care	Birth Weight _____
☐ Difficulty in labor /delivery	☐ Colic	☐ Parental separation	☐ DCFS involvement	

CSW Information NAME PHONE NUMBER : EMAIL:

Please elaborate on any checked items above