



The Children's Alliance of Hawaii, Inc.

Client Referral

O Heart

O Ho'omaka

O Strengthening Parents

Child's Name: Last First DOB: Age:

Mailing Address: Street City Island Zip Code

Ethnic Background: Education: (School or Level Completed)

With whom does child currently reside? O Parent(s) O Foster O Guardian O Group Home O Shelter

Current Guardian: Name Contact# Home Work Cell

If address is different from above: Street City Island Zip Code

Email Address:

Household's Annual Income Level:

O \$16,930 or less O \$16,931 - \$25,710 O \$25,711 - \$34,490 O \$34,491 - \$50,720 O \$50,721 or more

Confirmed Sexual abuse? O Yes O No Social Worker:

Phone/Fax:

Any Special Needs (diet, Rx, ESL, allergies, etc.)?

What would you say are child's strengths?

What would you say are areas in need of growth/attention?

Medical Coverage: HMO/Private Therapist: Name Agency

In case of emergency contact: Name contact # relationship

Transportation will be provided by: Name contact # relationship

Referral Source: Name agency date contact #

\*\*Please attach a current, brief sexual abuse history w/ referral: O Yes, hx is included O None available

I authorize (referring agency) to release information on the above named client to The Children's Alliance of Hawaii, Inc. who will use the confidential information for intake purposes. I hereby certify that the information provided above is accurate.

Parent or Legal Guardian Signature: Date:

Information gathered with this consent will not be shared with any party outside of CAH and the referring agency. Information received by CAH from a third party cannot and will not be shared with or without the consent of the client or the client's legal guardian. This consent can be cancelled at any time by writing to or phoning CAH staff.

OFFICE USE ONLY: Date Received: By: Referred to:

Rev 8/17/11

Fax Referral to: (808) 599-5909