CIRCLES OF CARE INC.

Your Choice for Quality Behavioral Healthcare Services

The Child Welfare Team

4450 West Eau Gallie Blvd. Suite 200, Melbourne, FL 32934
Office (321)726-2860 Fax (321)752-3143

Client Information

Name: _____ Sex/Gender Identification: ☐ Female ☐ Male ☐ _____

DOB: _____ SSN: _____ Marital Status: _____

#Household members: _____ Ages: _____

Language Preference: _____ Pregnant: ☐ No ☐ Yes If yes, Date Due: _____

Address: _____ City/State/Zip: _____

Phone #: _____ Alternate Phone #: _____

Insurance Information

Health Insurance Company: _____ Plan ID#: _____

Other Health Insurance: _____ Other Health Insurance #: _____

Referral Source

Person Referring: _____ Agency: _____

Phone: _____ Email: _____

Presenting Problems

To be referred to our program, the individual must be a parent, and have mental health and/or substance use problems. Please describe reason for referral, and list any prior diagnoses:

_____

_____

Type of Drug(s) Using: _____

Date Drug Tested: _____ Results: ☐ Positive for: _____ ☐ Negative

Other agencies involved: _____

Services

We utilize a team approach with the Child Welfare Program, if admitted, the client will receive and be expected to actively participate in Mental Health assessment and ongoing therapy, Substance Abuse assessment and ongoing counseling, Peer Support services, as well as be assigned a Care Coordinator to assist with all of their case management needs.

Submitted by: _____ Agency: _____

Contact Phone# _____ Date Submitted: _____