DSCYF Department of Services for Children, Youth & Their Families | PREVENTION & BEHAVIORAL HEALTH SERVICES

Intensive Family Consultation (IFC) Referral

Date of Referral: DOB:

REFERRED CHILD: SCHOOL:/GRADE:

PARENT/LEGAL GUARDIAN ***(IF APPLICABLE):***
TELEPHONE NUMBER:
EMAIL:
ADDRESS:

REASON FOR REFERRAL: *Please check all that apply*

- ☐ Family Stressors
- ☐ Family Conflict
- ☐ Home Concerns (homelessness, etc. specify below)
- ☐ Peer Conflict/Interpersonal Problems/Bullying
- ☐ Parent/Child conflict
- ☐ Trauma
- ☐ Verbal Aggression, Physical Aggression or Negative Conduct
- ☐ Other-Describe:

Which reason above is the family's primary concern?

Please provide a brief description of the concerns prompting this referral:

Has the Parent/Guardian been made aware of the IFC referral? ☐ Yes ☐ No

Does the referral source want to be made aware of the outcome? ☐ Yes ☐ No

Referral Source Information:

Name: Role w/ Family:

Email: Contact Number:

Signature:

Family Household Information:

Please list all children in the home:

Name	Gender	DOB	Race
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

Please list all adults in the home:

Name	Gender	DOB	Race	Relationship to Child:
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

Additional Information:

Scan/Email Referrals: PBHS_Prevention_Inquiries@delaware.gov **Attn:** Neyssa Sealy

Delaware Youth and Family Center
1825 Faulkland Rd., Wilmington, DE 19805
(Fax) 302-622-4475

Mobile Crisis Service is available 24 hours/day, 7 days/week
1-800-969 HELP(4357) Statewide