State of Delaware

The Department of Services for Children, Youth and Their Families

Division of Prevention & Behavioral Health Services

"Integrating prevention, early intervention and mental health to enhance services for children & families"

Intensive Family Consultation (IFC) Referral

Child/ Family Member referred:

CHILD: DOB: SCHOOL:/GRADE:

Date of Referral: **Referral Source Name:**

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

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

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

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:

Referral Source Information:

Name: Role w/ Family: Phone #:

Email:

Signature

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Delaware Youth and Family Center
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