The Children's Alliance of Hawai'i, Inc.

Client Referral Form

☐ **HEART** ☐ **Ho'omaka** ☐ **Pinao** ☐ **Strengthening Parents**

Child's Name: _____ DOB: _____ Age: _____
Last First

Mailing Address: _____
Street City Zip Code

Ethnicity: _____ Gender Identity: _____ Education: _____
(School and/or Level Completed)

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

Current Guardian: _____
Name Contact# Home Work Cell

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

Email Address: _____

History of Abuse: ☐ Sexual ☐ Physical ☐ Severe Emotional ☐ Severe Neglect

Therapist and/or Social Worker: _____ _____
(if known) Name Agency Contact phone #

Email address: _____

A few words to describe the child's strengths:

Briefly describe areas in need of growth/attention:

Referred by: _____ _____ _____
Name Agency Date Contact phone #

Email address: _____

Please attach a current, brief sexual abuse history with referral form: ☐ Yes, history included ☐ None available

I authorize (referring agency) _____ to release information on the above named client to The Children's Alliance of Hawa'ii, 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 calling CAH staff at 599-2955.

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

Fax referral form to (808) 599-5909 or email to programs@childrensalliancehawaii.org.