Counseling Services PLLC

PSB-CBT REFERRAL SHEET

Contact Person: Tana Blackburn 336-818-0733 ext. 201
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- ☐ Ages 7-18
- ☐ Caregiver involvement required
- ☐ Each youth will be assessed by a licensed clinician to ensure criteria is met.

Date:_____ Alpha#_____

Child'slastname:_____Child'sfirstname:_____

County:_____DOB:_____Age:_____Ethnicity:_____ Gender:_____

ClientAddress:_____
Street City State Zip Code

Homephone:_____ Work/Cellphone:_____

LegalGuardian:_____Relationship:_____

Insurance:_____

ReferralSourceContactPerson:_____ _____
First Last

Whatare the specific sexual behaviors orconcerns that the childhas demonstrated?

Whendidthelastincidentoccur?_____Howmanyincidentsare known?_____

With whomdid the childhave the problematic sexual behaviors?

Name	Age	Relationship	Needservices related to incident?

Has the child ever initiated sexualcontact? ☐ Yes ☐ No Wascoercionused? ☐ Yes ☐ No

Does the child have additional behavioralconcerns?

Has child had a victimization experience? ☐ Yes ☐ No ☐ Suspected