



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's last name: _____ Child's first name: _____

County: _____ DOB: _____ Age: _____ Ethnicity: _____ Gender: _____

Client Address: _____
Street City State Zip Code

Home phone: _____ Work/Cell phone: _____

Legal Guardian: _____ Relationship: _____

Insurance: _____

Referral Source Contact Person: _____
First Last

What are the specific sexual behaviors or concerns that the child has demonstrated?

When did the last incident occur? _____ How many incidents are known? _____

With whom did the child have the problematic sexual behaviors?

Name	Age	Relationship	Needs services related to incident?
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has the child ever initiated sexual contact? ☐ Yes ☐ No Was coercion used? ☐ Yes ☐ No

Does the child have additional behavioral concerns? _____

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