



The Toby Center for Family Transitions
Improving Outcomes for Children When Parents Choose to Separate
 Visitation * Mediation * Parent Education * Family Therapy
www.thetobycenter.org 855-862-9236, Ext. 4 ekc1019@yahoo.com

Today's Date: _____

Referral Form Completed by:

Name: _____

Title: _____

*****Office Use Only*****

Interviewed by: _____

Approved: _____

Date of Referral: _____

AGENCY REFERRAL FORM

CASE INFORMATION:

CLIENT* _____ CASE #: _____

Is Visitation Court Ordered? YES NO TODAY'S DATE: _____

If YES, please provide a copy of the court order or parenting plan.

Service Requested:

- Monitored Child Exchange Telephone or Web Visit Standard Supervised Visitation
 Therapeutic Supervised Visitation Family Therapy Other _____

Frequency of Each Visit: _____ Times per _____ Duration : _____ Hours

Visit Location: Toby Center Facility Community Parent Home
 Other: _____

Expected Time Frame for Visitation: 30 Days 60 Days 90 Days 120 days Other _____

*Client: Please complete **entire** form. All spaces must be filled. If a question does not apply to you, please write N/A in the blank.*

VISITING PARENT INFORMATION:

Last _____ First _____ Middle _____

Street Number _____ Street Name _____ Apartment or Unit Number _____

City _____ State _____ Zip + 4 _____

Home Tel: () _____ Cell: () _____ Work: () _____

d.o.b. _____ Ethnicity: _____ Primary Language: _____

Referring Agency: Family Court DCF Juvenile Court Other _____

Attorney : _____ Tel: () _____ E-Mail: _____

Case Mgr/ Worker: _____ Tel: () _____ Fax _____ E-Mail: _____

GAL on _____ Tel. () _____ Fax _____ E-Mail: _____



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Case: Y/N _____

Pending Criminal Action YES NO

If yes, please explain (dates, charges and special requirements) _____

Is client currently on parole or probation? YES NO

If Yes, where? (Federal, State, County or City) _____

Probation/Parole Officer: _____ Tel: () _____ E-Mail: _____

CHILDREN:

Full Name	Nickname	Date of Birth	Parent Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT INFORMATION:

Last _____ First _____ Middle _____

Street Number _____ Street Name _____ Apartment or Unit Number _____

City _____ State _____ Zip + 4 _____

Home Tel: () _____ Cell: () _____ Work: () _____

IMPORTANT Please must provide ALL copies of current court orders. Please include: Orders of Protection, Parenting Plans (proposed and final plans) **most current** Dependency Orders. ATTACHED? YES NO

Do you have a current Order of Protection or No Contact Order? If yes:

Name(s) of persons the Order protects : _____

Name(s) of the person(s) the order restrains: _____

CUSTODIAL PARENT INFORMATION:

Last _____ First _____ Middle _____

Street Number _____ Street Name _____ Apartment or Unit Number _____

City _____ State _____ Zip + 4 _____



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Home Tel: () Cell: () Work: ()
 d.o.b. Ethnicity: Primary Language:
 Attorney: Tel: () E-Mail:
 DCFS Worker: Tel: () Ofc: E-Mail:
 Car Make: Model: Color: Year:
 License Plate # State:

OTHER PARTIES:

NAMES OF INDIVIDUALS WHO ARE AUTHORIZED TO ATTEND VISITATION (PLEASE PROVIDE WRITTEN AUTHORIZATION FROM YOUR CASEWORKER, CUSTODIAL PARENT, A COPY OF PARENTING PLAN OR A CURRENT COURT ORDER)

Child(ren) Involved	d.o.b.	Gender	Relationship	In Custody Of
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____

NAMES OF INDIVIDUALS WHO ARE NOT AUTHORIZED TO ATTEND VISITATION

Adult(s) Involved	d.o.b.	Gender	Relationship
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	_____

REASONS FOR REQUESTING SUPERVISED VISITATION (please check all that apply) :

- | | |
|--|---|
| <input type="checkbox"/> Separation / Divorce | <input type="checkbox"/> Custody Dispute |
| <input type="checkbox"/> | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> DCF Allegations of: | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Reunification | <input type="checkbox"/> Substance Abuse Issues |
| <input type="checkbox"/> Normalization of Parenting Relationship | <input type="checkbox"/> Domestic Violence |
| | <input type="checkbox"/> Sexual Abuse |
| | <input type="checkbox"/> Other: |

****IMPORTANT** MUST READ****

The Toby Center requires complete background information in order to consider the case for acceptance. We need to know of childhood traumas, mental illness, drug or alcohol abuse. We require a copy of a) court orders; b) psychological evaluations; c) record of criminal and or domestic violence charges and convictions; d) restraining orders. Upon assignment, further inquiry and review will be required.

THIS REFERRAL WILL BE INCOMPLETE AND ASSIGNMENT WILL BE DELAYED IF BACKGROUND INFORMATION IS NOT ATTACHED. WITH CLIENT AND OR CUSTODIAL PERMISSIONS, YOU MAY EMAIL RECORDS TO ekc1019@yahoo.com Delays to case information requests may result in termination of case.



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The Toby Center will conduct an intake with client, request background information and may terminate services if client situation is blocked, completed or does not have complete information to provide appropriate requested service.

 Signature of Referring Agency Contact Date

*******For Office Use Only*******

Contracting Party: Family Court DCFS Parent Other _____

Contract # _____

Agency Contact: _____ Tel: () Fax: () E-Mail: _____

Address: _____
Street City State Zip

Payment Method: Invoice P/O Cash Money Order Other _____

NOTES: (PLEASE ATTACH ADDITIONAL SHEET IF NECESSARY)

*******FORMS REQUIRED FOR FILE*******

Please check off forms to be provided by referral party client

FORM

VERIFIED BY



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**Are you
any of
following:
check**

<input type="checkbox"/>	Intake Form	_____
<input type="checkbox"/>	Client Information Form	_____
<input type="checkbox"/>	Prevailing Court Order	_____
<input type="checkbox"/>	Consent to Release of Information	_____
<input type="checkbox"/>	Emergency Protocol	_____
<input type="checkbox"/>	Hold Harmless Form	_____
<input type="checkbox"/>	Visitation Guidelines	_____
<input type="checkbox"/>	Visitation Plan	_____
<input type="checkbox"/>	Copy of Driver's License	_____
<input type="checkbox"/>	Copy of Auto Insurance	_____
<input type="checkbox"/>	Current paystub if client paying for service	_____
<input type="checkbox"/>	Anything else deemed helpful to service	_____

**providing
the
Please**

applicable box below. Thank you.

**Please complete and return forms to:
ekc1019@yahoo.com & info@thetobycenter.org**