Progressive Community
Care Center

RECIPIENT REFERRAL SHEET **Choose One:** □ **Laplace Office** □ **Orleans Office**	
RECIPIENT NAME:	
AGE/D.O.B.:	
MAILING ADDRESS:	
PHYSICAL ADDRESS (if different than mailing):	
PARENT/GUARDIAN NAME (if applicable):	
HOME PHONE:	
CELL PHONE:	
WORK PHONE:	
ALTERNATE PHONE (if applicable):	
REFERRED BY:	
CHIEF COMPLAINT:	□ Difficulty concentrating, focusing, sitting still, following through, and/or being successful in day to day obligations (school or work) □ Recent Trauma or Loss □ Emotional Troubles □ School Suspension □ Academic Failure / Repeated Grades □ School Expulsion / Alternative School Placement □ Arrest □ Psych Hospitalization □ Foster Care Placement □ DCFS Involvement □ Hx of Danger to Self/Others □ Significant Medical Conditions: □ Other:

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