A LIFEBRIDGE HEALTH GROUP
CENTER FOR HOPE
Baltimore Child Abuse Center

Center for Hope Mental Health Referral Date of Referral:

Please complete this form in its entirety and email to CFH_mentalhealth@lifebridgehealth.org

Referring Provider

Name:

Agency:

Phone number:

Email:

☐ In-person ☐ Telehealth ☐ Minor ☐ Adult

Client Information

Client Name:

Date of Birth:

Legal Guardian Name (if applicable):

Phone:

Email:

☐ Guardian ☐ Client ☐ Guardian ☐ Client

Best time to be reached:

Preferred Language: Choose an option. Ethnicity

Client Address:

Zip code:

Relationship of Legal Guardian to Client:

☐ Biological Parent ☐ Relative with Legal Status
☐ Foster parent ☐ Other (explain):

Reason for Referral (please include trauma):

Common Trauma Symptoms (check all that apply):

☐ Sleep disturbances ☐ Nightmares ☐ Increased aggression
☐ High irritability ☐ Suicidal Ideation ☐ Lack of interest in enjoyable activities
☐ Difficulty concentrating ☐ Homicidal Ideation ☐ Prolonged negative thoughts/feelings
☐ Increased Isolation ☐ Increased need for attention
☐ Other:

Type of Trauma Exposure (check all that apply):

☐ Child maltreatment ☐ Sexual abuse ☐ Anti-trafficking &exploitation
☐ Community violence (nonfatal shootings, etc.) ☐ Runaway/missing youth
☐ Homicide witness/victim survivor (date of death:)
☐ Intimate Partner Violence (domestic violence)
☐ Child Imagery