PRS Changing Lives. Saving Lives.

Family Peer Support Partner Services

Referral Form

Referral Date:		Referring Worker/Agency:
Case Type __ICC ___FRM ___FPM ___MDT __Other (Please indicate):		
Phone	Fax	Email
Background Information		
Youth Name		Case ID (if applicable)
Gender	Ethnicity	DOB
Stress Address		
Parent Guardian Names (s):		
Phone (s):	Email:	Primary Language:
Youth and Family (CANS MUST BE SUBMITTED WITH REFERRAL)		
Diagnosis (if known):		Risk Factors Identified:
Brief Explanation of youth and family needs, concerns, current situation and/or purpose of referral:		
Date (s) of most recent CANS: _____		
Current Services/Placements (Required)		

If youth/family is receiving and is expected to continue receiving any of the following while received FPSP services please check all that apply:

- ☐ Diagnostic/Evaluation/Assessment Services
- ☐ Intensive Home-Based Services
- ☐ Intensive Day Treatment Services
- ☐ Therapeutic Foster Care
- ☐ Recovery Support Services (i.e Support Employment)
- ☐ Outpatient Services
- ☐ Crisis/Emergency Services
- ☐ Respite Care
- ☐ Transition to Adult services
- ☐ Other/please name: _____

Additional Information

To submit this form: Send form via an encrypted email to fspreferrals@prsinc.org

or

Mail Form to:

Attn: Family Support Services
10455 White Granite Oak Drive, Suite 400 Oakton, VA 22124