Thriving Beyond Boundaries

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CLTS Referral Intake Form

Client Information

Child's Full Name: _____

Date of Birth: _____ Gender: _____

Parent/Guardian Name(s): _____

Phone Number: _____ Email: _____

Home Address: _____

Emergency Contact Person: _____ Phone Number: _____

Referral Source

Referring Agency: _____

Referring Case Manager/Social Worker: _____

Phone Number: _____ Email: _____

Date of Referral: _____

CLTS Services Requested

☐ Mentorship ☐ Respite Care ☐ Daily Living Skills

☐ Community Integration ☐ Social/Emotional Skills ☐ Recreational/Wellness Activities

☐ Other: _____

Service Goals or Focus Areas

(Briefly describe why the child is being referred, including primary goals or needs.)

_____

_____

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Diagnosis or Primary Support Needs

☐ Autism Spectrum Disorder ☐ Anxiety/Depression ☐ Development Disability

☐ Behavioral/Emotional Regulation ☐ Physical Disability

☐ Other: _____

Preferred Schedule / Availability

☑ Weekends ☐ Evenings ☐ Weekends ☐ Flexible

Specify times or notes:

_____

_____

Safety or Behavioral Considerations

(List any known triggers, medical needs, allergies, or safety concerns.)

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Additional Notes or Requests

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Approved Hours Per Week

Thriving Beyond Boundaries | Staff Section

_____

_____

_____

_____

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