Family Service Center
OF GALVESTON COUNTY

REFERRAL FORM

Please provide as much information as possible to assure that your referral receives the most appropriate attention available. Fax to 409-938-4849

Date: _____

Agency making referral: _____

Your Name: _____ **Phone Number:** _____

Client's Name: _____

Is the client a minor? ☐ YES ☐ NO School child attends: _____

If yes, name(s) of parent/guardian: _____

Client's DOB: _____ **Sex:** _____ **Race:** _____ **Hispanic/Latino:** ☐ YES ☐ NO

Address: _____
Street City Zip

Preferred Phone Number: _____ **Is it safe to leave a message?** ☐ YES ☐ NO

Primary Language of Client: ☐ English ☐ Spanish ☐ Other _____

Program being referred to:

- ☐ Family and Youth Success/FAYS (Previously STAR – school based counseling for children ages 0-17)
- ☐ Victim Support Services (VOCA)
- ☐ Individual & Family
- ☐ Non-Profit MH Assistance Program
- ☐ Healthy Moms Program (to assist with Post Partum Depressive Symtpoms)

Presenting Problems/Reasons for Referral:

_____

_____

_____

_____

Island Office
2200 Market Street
Suite 600
Galveston, TX 77550
(409) 762-8636
Fax: (409) 762-4185

Mainland Office
10000 Emmett F. Lowry Expressway
Suite 40000-300D
Texas City, TX 77591
(409) 938-4814
Fax: (409) 938-4849

Toll Free: 1-888-267-4994 **Web:** www.fsc-galveston.org

United Way of Galveston

United Way
Galveston County Mainland