

Coastal Horizons Center Incredible Years Referral Form

For consideration for acceptance into the Incredible Years Program, please complete the following referral form and return to the fax number on the last page of this form.

Information gathered from this referral is confidential and will be used to consider whether the parent / caregivers and child meet the criteria for parents / caregivers to attend The Incredible Years Program. This decision will be made in collaboration with the child's family.

Criteria will include that family members are motivated to attend the Program after discussion / interview with The Incredible Years facilitators employed by Coastal Horizons.

NOTE: *If you are referring parents as part of your work with an agency or organization your ongoing involvement and support for the parent/s for the duration of the Program will be appreciated. Parents will need your support during the course and the more you can meet with them to encourage, celebrate their success, talk about the key concepts and their weekly goals, and model/coach them as they practice with their children, the better. You will also be a key link for the facilitators should there be changes in the families' circumstances that may impact on their ability to participate fully.*

Consent for Referral for participation in the Incredible Years Program: (Signed by Parent/Caregiver): I consent for a referral to be made to The Incredible Years Program.

Name (Please Print):

Signature:

Date:

Date of Referral:	
Name of Referrer:	
Contact details of Referrer: Name and address of organization:	
Telephone/s:	
E-mail:	

Parent/Family wishing to attend Incredible Years:	
Name/s:	
County of Residence:	
Address:	
Zip:	
Telephone/s:	
E-Mail:	
Relationship to child:	

Details of child whose behavior is of concern:	
Name:	
DOB:	
Sex:	
Diagnosis: (if applicable)	

Other children in family	
Name:	Name:
Age:	Age:
Name:	Name:
Age:	Age:

Name of school or early childhood center child attends (if applicable)

Other agencies/organizations involved with supporting the family

Reason for Referral: *(The behavior of concern, when it began, what you have tried)*

Please return referral form to:

Nicole Malnar, Lead Faciltator	or	Andrea Bowens, Co-Facilitaor
910-523-3016		910-202-0840
nmalnar@coastalhorizons.org**		abowens@coastalhorizons.org**
Fax: 910-202-5772		Fax: 910-202-0843

***Please note. Do not email this referral form as it contains confidential information. Email is provided for contact purposes only. You may fax this form or call/email a facilitator to schedule an in-person pick-up.*