Child and Family Team Service Request

** This form is to be reviewed by the family (parent/guardian) and the team (i.e., therapist, psychiatrist, care manager, primary care physician, teacher, etc.) and **must** include the signatures for team members, especially the parent/guardian and person completing the SPOA referral.*

*** In cases where you are unable to get a signature, please contact Children's SPOA Coordinator Erin Velsini at 518-873-3670 to discuss options.*

Name of Child _____

Date _____

Current Services _____

_____

_____

_____

Needs Identified _____

_____

_____

_____

Additional Information _____

_____

_____

SPOA Referral Recommended YES _____ **NO** _____

Team Member Completing SPOA Referral: _____

Team Member Signatures	**Relationship to Child**
_____	_____parent/guardian_____
_____	_____parent/guardian_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Team Contact Person/Contact Number: _____