Please send referrals to:
Clinical Supervisor
Kathy Kane, LCSW
Fax: 908-454-9871
kkane@ccdom.org
Phone: 908-454-2074

CATHOLIC CHARITIES
Diocese of Metuchen

ALTERNATIVES REFERRAL

Program Highlights:

- An ***alternative*** to traditional out-patient services
- 6 months of in-home therapy
- Psychiatric services available
- Designed to overcome barriers such as transportation, insurance, or resistance to traditional treatment

Client Name: _____ **Client DOB:** _____

Parent(s)/Guardian (s) Name (s): _____

Home address: _____

Parent(s)/Guardian(s) Phone Number(s): _____

Any recent past psychiatric hospitalizaions (past 6 months): ☐ Yes ☐ No

Reason for referral (please describe current presenting problem):

_____

It is important that the family know that a referral has been made on their behalf.

Has the family been involved with this referral process/planning: ☐ Yes ☐ No

Name of person making referral/agency: _____

Referral source contact information: _____