Pechanga Tribal TANF Program

P.O. Box 1477 • Temecula, CA 92593 • Telephone (951) 770-6000

Pechanga Interagency Referral Form

Referring Department:		
Name of Referrer:	Job Title:	Department:
Email:	Date of Referral:	☐ Routine ☐ Urgent

Client Information:			
Name:	DOB:	Age:	Gender: ☐ Male ☐ Female
Are they an enrolled member of Pechanga: ☐ Yes ☐ No	Contact Phone #		
Tribal affiliation, if not a Pechanga member:			
Do they live on the Pechanga Indian Reservation or within Orange or Riverside County: ☐ Yes ☐ No			
Does the applicant attend Pechanga School: ☐ Yes ☐ No	If yes, do you want them to be seen during school hours? ☐ Yes ☐ No		
What is your availability?	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday		
Any Special Needs/Disabilities: ☐ Yes ☐ No	If yes, explain:		

If the client is a Minor (under 18 years):

Have you discussed this referral with all those who hold parental responsibility? ☐ Yes ☐ No *(If you answered No, please explain why you think it is in the minor's best interest to proceed without doing so.)*

Name of Primary Parent/Caregiver:	Relationship to Minor:

Contact Information for Parent/Caregiver:	Home Phone #	Cell Phone #

Reason for Referral/Background Information:

How was contact initiated? ☐ Client ☐ Parent/Caregiver ☐ School/Teacher ☐ Tribal Court ☐ Other

Are there any issues we should be aware of when contacting parents/caregiver? ☐ Yes ☐ No (If yes, explain below):

Why are you referring this client? What has happened? What are the concerns based on? (explain below)

What Agencies Need to be Involved?

Name of Professional	Agency Name	Agency Role	Contact Details

Please Explain any Requested Services:

Details of Referral: PTG Staff Only

Referral Delivered Via: ☐ Phone (emergency only) ☐ E-mail ☐ In Person ☐ Interoffice Mail

Follow-up Expected Via: ☐ Phone ☐ E-mail ☐ In-Person ☐ Telehealth/Zoom

Name and Signature of Recipient:	**Date:**