Marley's Mission Referral Form

Mailing Address:
Attn: April Kemp, Program Director
2150 Port Royal Road
Clarks Summit, PA 18411

Farm Location:
2150 Port Royal Road Clarks
Summit, PA 18411 (570)
587-HOPE

"Marley's Mission is a place where hope comes alive for children and their families who have experienced trauma."

Today's Date: ______/______/_________

REFERRAL INFORMATION:

Referral Source: CAC Children & Youth Friendship House Other: ______________________

Referral Address: ____

Contact Person: ____

Contact Phone#: ____

PARTICIPANT INFORMATION:

Child's Name: ____

Child's Email: ____

Child's Phone #: ____

Gender: Male Female Non-Binary Transitioning DOB**:** _____/_______/_________ Age**:**______

Current Home Address: ____

City: ______________________________ State: _______ Zip Code: ___________County: _____________

Current School Grade: ______________ School Attending: ________________________

CLIENT DIAGNOSIS:

Briefly explain diagnosis

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____

DSM Code (if identified**):** ____

CURRENT MEDICATIONS: ____

PRESCRIBER: ____

LEGAL GUARDIAN INFORMATION:

Parent/Legal Guardian: ____

Identify Relationship to Child: Mother Father Legal Guardian Caseworker

If different from above, list names of biological/adoptive parents (if known):

Mother:____________________________ Father:____________________

Legal Guardians Phone #: ____

Legal Guardians email address: ____

Legal Guardians Address: ____

City: __________________________ State: ______ Zip Code: __________County: ________________

If the child is currently living in a foster home please provide the following information:

Name of caregiver: ____

Phone Number: _______________________ Email: ____

Home Address: ____

City: __________________________ State: ______ Zip Code: __________County: ________________

Child's Siblings:

Name	Age	Biological Sibling or Other (adopted, step, foster)	Live in Same Home as Child

THERAPIST INFORMATION:

Therapist Name: ____

Therapist Affiliation: ____

Therapist Address: ____

Therapist Phone: ____

Reason for seeking equine-assisted psychotherapy:

Briefly explain pertinent information related to the child's history of abuse or trauma.

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OTHER INFORMATION:

Was a Pennsylvania on Crime and Delinquency (PCCD) form filed? Yes No PCCD# (if known):

If PCCD was filed, but number is not available, what is the date PCCD was filed?: ___________________ Was a police report filed? Yes / No

If yes, what is police report #______________________________ (Please attach a copy of the police report.)

MEDICAL INFORMATION:

Are you aware of any immediate medical conditions for which **Marley's Mission, Inc.** should be aware before the child arrives at **Marley's Mission, Inc.**, such as nut allergies, bee allergies, asthma, epilepsy, heart conditions, etc.)

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If you have any questions, contact April Kemp (Founder and Program Director) at aprilkemp@marleysmission.com or our clinical director Kimberly Portanova Feibus at kim@marleysmission.com or call 570-587-HOPE.

Please email the completed referral form