

*The Center for Personal Growth*  
 4656 30<sup>th</sup> St., San Diego, Ca. 92116  
 Telephone: (619) 405-6378  
 Fax: (619) 528-8054

## Rainbow Group Referral Form

Name of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Our goal at the Center for Personal Growth is to provide a safe environment for all of our clients.

### **Inclusion Criteria (check all that apply):**

Does the client self-identify as being part of the LGBTQ community  Yes  No

The client has the ability to participate in group therapy (i.e. sitting, attending, answering questions, participating, etc.)  Yes  No

### **Exclusion Criteria (check all that apply):**

The person has a history of being AWOL.  Yes  No

The person has a high degree of self injurious behavior .  Yes  No

The person is physically or verbally aggressive.  Yes  No

The person has a history of property destruction.  Yes  No

The person has a seizure disorder not reliably controlled by medication.  Yes  No

The person requires assistance with bathroom use.  Yes  No

The person has a history of fire setting behavior.  Yes  No

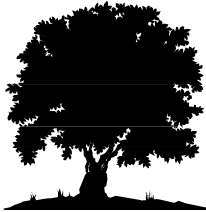
The person has a history of inappropriate sexual behavior.  Yes  No

The person has problematic substance abuse.  Yes  No

The person does not use words to communicate and does not have appropriate facilitation available.  Yes  No

If you answered “Yes” to any exclusion criteria, please provide details:

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**General Information:**

Name of Client: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Check One:  Home  Cell

Date of Birth: \_\_\_\_\_

Type of residence: \_\_\_\_\_

Email: \_\_\_\_\_

\*Monthly email reminders will be sent to this email address one week prior to the group.

**Emergency Contact Information:**

Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Telephone (Day/Evening/Cell): \_\_\_\_\_

**Additional Support People:**

Name: \_\_\_\_\_ Tel.#: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Tel.#: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Legal Representative:**

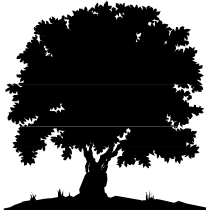
Does the client have a conservator?

Yes **If Yes... YOUR CONSERVATOR MUST ATTEND THE INTIAL SCREENING APPT.**

No

If Yes, name of conservator or legal representatives: \_\_\_\_\_

Telephone number of conservator or legal representative: \_\_\_\_\_



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**San Diego Regional Center:**

Who is your SDRC Service Coordinator (Print Name): \_\_\_\_\_

SDRC Service Coordinator's Telephone number: \_\_\_\_\_

Office where your SDRC Service Coordinator is located (Check One):

- 4355 Ruffin Road, San Diego, Ca. 92123
- 8760 Cuyamaca St, #100, Santee, Ca. 92071
- 2727 Hoover Ave, #100, National City, Ca. 92150
- 5931 Priestly Drive, Suite 100, Carlsbad, CA 92008

**Reason for referral:**

What interested you in this group and what is your goal in being a part of this group?

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Print Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for completing the Rainbow Group Referral Form. You have three options to submit this form:

1. Fax this form to The Center for Personal Growth, Inc. at 619-528-8054.
2. Mail this form to the address listed above.
3. Scan this form and email it to [BNewcomer@centerforpg.com](mailto:BNewcomer@centerforpg.com).

This information will be reviewed by a staff member who will contact you to discuss the content and/or schedule an initial screening appointment with the client.