Children's Alliance of Montana ◈ Montana Rural Telemental Health Project
P.O. Box 666, Billings, MT 59103 ◈ www.childrensalliancemt.org

Montana Rural Telemental Health Project - Referral Form B for Therapists

This form should be completed by the referrer (i.e., victim advocate, CPS worker, etc.) after completing Referral Form A. If the information requested has already been collected elsewhere, the referrer may reference those records to complete this form. For any field(s) that cannot be answered via existing records, the referrer should ask the caregiver directly and write down their response. The referrer will share this information directly with the therapist once a therapist has been assigned.

****Please DO NOT send this form to CAM.****

Child and Caregiver Contact Information

1. Child's Name: _____
2. Child's Date of Birth: _____
3. CFS CAPS ID #: _____
4. Caregiver Name: _____
5. Caregiver Email: _____
6. Caregiver Phone: _____
7. Caregiver Facebook Messenger: _____
8. Other preferred way to contact caregiver (method & contact details):

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