AMISTAD
FAMILY SERVICES, INC.

3100 Oak Street
Las Cruces, NM 88005-3769
www.afsnm.com (575) 523-2288 phone (575) 523-2299 fax

Third Judicial District Infant Mental Health Team Referral Form

Date:	Time:

Referral Source Information:		
Name of CYFD/PS Worker:	Job Title:	Telephone Number:
CAPTA Referral to FIT	☐ Yes ☐ No	Date Sent:

Child/ren's Details					
Name	DOB	Gender	Social Security #	Medicaid #	In Childcare Y/N
Primary Language:			Medical Needs:		

Parent(s)/Caregiver(s) Details				
Name	Relationship	Address	Home Number	Cell Number
Foster Parent(s)/Current Placement Details				
Name	Relationship	Address	Home Number	Cell Number

Have visits been scheduled? ☐Yes ☐No
If so please list where, dates, and times:

Legal Dates				
Date of Custody	10-Day Hearing	Adjudicatory Hearing	Other Court Dates	Other Meeting Dates

Legal Assignments	
Guardian Ad Litem (GAL)	
CASA Worker	
Respondent's Attorney (Mother)	
Respondent's Attorney (Father)	

Please include any additional information:

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THIS SECTION TO BE COMPLETED BY IMHT ONLY

Infant Team Clinician Assigned for Intake:
Date Assigned:
Date Intake Scheduled:

Additional Notes: