CHARISSA D.
PIZARRO, PSY.D
Psychological Services LLC
430 Central Ave
Jersey City, NJ 07307
973-520-6831
DrPizarro@DrCharissaPizarro.com

DCP&P REFERRAL & CONSENT FORM

(For Therapy and Clinical Services)

CASE INFORMATION

NJS ID: _____ Division Office / Local Office: _____

Date of Referral: _____

SECTION 1 – FAMILY INFORMATION

Family Name: _____

Address: _____

City/State/ZIP: _____

Primary Telephone/ email: _____

Primary Language: _____

Household Members:

Name	Date of Birth	Relationship
1.		
2.		
3.		
4.		

SECTION 2 – REFERRAL DETAILS

Reason for Referral: _____
_____
_____

Current DCPP Involvement: _____
_____

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Risk Factors (e.g., substance use, domestic violence, psychiatric history, safety concerns):

_____

_____

Family's Relationship with DCPP: ☐ Positive ☐ Cooperative ☐ Uncooperative ☐ Hostile ☐ Other: _____

Anticipated Behavior During Services:

_____

Recommended Service Modality (check one): ☐ In-Person ☐ Telehealth ☐ Hybrid / TBD

Type of Service Requested: ☐ Individual Therapy ☐ Family Therapy ☐ Parenting Support ☐ Psychological Evaluation / Assessment ☐ Sexual Abuse Treatment Program ☐ Supervised or Therapeutic Supervised Visitation (only offered in person)

Referral Priority: ☐ Routine ☐ Urgent

Availability for Services (days/times):

_____

If this is a referral for a psychological evaluation, what is the referral question?

_____

Other Agencies Involved or Referred To:

_____

Additional Comments or Instructions:

_____

_____

SECTION 3 – CONSENT FOR REFERRAL AND TREATMENT

I have been informed that my DCPP caseworker is referring me and/or my family for therapeutic services through Charissa D. Pizarro, PsyD Psychological Services, LLC. I consent to participate in treatment and agree to attend scheduled sessions.

I authorize the release and exchange of information between my DCPP caseworker and Dr. Pizarro's practice, including progress reports, attendance, and treatment summaries. I understand that my treatment records belong to DCPP, and that any requests for copies must be made through DCPP or by court order.

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Me han informado de que mi trabajador(a) de DCPP me está refiriendo a mí y/o a mi familia a los servicios terapéuticos de Charissa D. Pizarro, PsyD Psychological Services, LLC. Doy mi consentimiento para participar en el tratamiento y me comprometo a asistir a las sesiones programadas.

Autorizo la divulgación y el intercambio de información entre mi trabajador (a) de DCPP y la consulta de la Dra. Pizarro, incluidos los informes de progreso, la asistencia y los resúmenes del tratamiento. Entiendo que mis registros de tratamiento pertenecen a DCPP y que cualquier solicitud de copias debe realizarse a través de DCPP o por orden judicial.

Client(s) / Parent / Guardian: _____ Date: _____

Client(s) / Parent / Guardian: _____ Date: _____

DCPP Caseworker:
Name: _____ Phone: _____
Email: _____ Division Office: _____
DCPP Supervisor:
Name: _____ Phone: _____
Email: _____

Program Liaison (Practice Representative): _____ Date: _____

Accepted by (Practice Representative): _____ Date: _____

OFFICE USE ONLY

Date Referral Received: _____

Date Contacted Family: _____ Date Contacted DCPP Worker: _____

Assigned Clinician: _____Intake Date: _____

Note: Please attach the DCPP Assessment or Investigative Report (Form 26-81), relevant evaluations, and any court or service documentation to complete this referral.

This referral form contains confidential client information. Please transmit via secure email in compliance with HIPAA and DCPP confidentiality guidelines.