



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: _____

Primary Language: _____

Household Members:

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

SECTION 2 - REFERRAL DETAILS

Reason for Referral: _____

Current DCP&P Involvement: _____



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

Family's Relationship with DCP: ☐ 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

Referral Priority: ☐ Routine ☐ Urgent

Availability for Services (days/times):

Other Agencies Involved or Referred To:

Additional Comments or Instructions:

SECTION 3 – CONSENT FOR REFERRAL AND TREATMENT

I have been informed that my DCP 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 DCP caseworker and Dr. Pizarro's practice, including progress reports, attendance, and treatment summaries. I understand that my treatment records belong to DCP, and that any requests for copies must be made through DCP or by court order.

Me han informado de que mi trabajador(a) de DCP 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.



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Autorizo la divulgación y el intercambio de información entre mi trabajador (a) de DCPD 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 DCPD y que cualquier solicitud de copias debe realizarse a través de DCPD o por orden judicial.

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

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

DCPD Caseworker:

Name: _____ Phone: _____

Email: _____ Division Office: _____

DCPD 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 DCPD Worker: _____

Assigned Clinician: _____ Intake Date: _____

Note: Please attach the DCPD 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 DCPD confidentiality guidelines.