Date: [Date]

To: [Name of Mental Health Professional/Clinic]
Address: [Clinic Address]
Phone/Email: [Contact Information]

RE: Referral for Child-Centric Family Counseling

Patient/Client Name: [Child's Name]
Date of Birth: [Child's DOB]
Parents/Guardians: [Names of Parents/Guardians]

Dear [Provider Name],

I am writing to formally refer the above-named child and their family for child-centric family counseling services. The primary goal of this referral is to support the child's emotional and behavioral well-being within the family dynamic.

Reason for Referral:
[Briefly describe the primary concerns, e.g., behavioral changes, emotional distress, or difficulty coping with family transitions.]

Background Information:
[Provide brief context, e.g., recent divorce, school difficulties, or trauma symptoms.]

Specific Objectives:
1. To provide the child with a safe space to express feelings.
2. To improve communication between parents and the child.
3. To implement age-appropriate coping strategies for the child.
4. To assist parents in developing child-focused parenting techniques.

Please contact the family at [Phone Number] or [Email Address] to schedule an initial intake assessment. If you require any additional documentation or clinical notes, please do not hesitate to contact my office.

Thank you for your professional assistance in supporting this family.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Credentials]
[Your Organization]
[Your Contact Information]