



Los Angeles County Department of Mental Health Parent Child Interaction Therapy (PCIT) Referral Form

PCIT is an Evidence-Based Program that is for young children, ages 2 to 7, with externalized acting out behaviors that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. It has been successfully used to help young children who may have serious behavioral problems such as aggressiveness, defiance, temper tantrums and oppositional behaviors.

Referral Date				
Date:				
Client Information				
Client Name:	DOB and Age:	IBHIS #		
Gender:	Phone:	Preferred Language:		
Address:	City:	Zip Code:		
Placement Type (if applicable):	DCFS Name/Contact (if applicable):	Medi-Cal #:		
Referring Provider Information				
Provider Name & Provider #:		Referring Practitioner/Title:		
Phone:		Email		
Caregiver Information				
Primary Caregiver Name:	Relationship to Child:	Preferred Language:		
Translation Needed: ☐ Yes ☐ No ☐ Unsure	Willing to participate weekly: ☐ Yes ☐ No ☐ Unsure	Able to attend consistently: ☐ Yes ☐ No ☐ Unsure		
Does caregiver see the child in the home at least 3xs per week: ☐ Yes ☐ No ☐ Unsure	Any barriers (transportation, schedule, etc.): ☐ Yes ☐ No ☐ Unsure	If barriers exist, please explain:		
Presenting Concerns (check all that apply)				
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border-right: 1px solid black; padding-right: 10px;"> ☐ Frequent tantrums ☐ Aggression (verbal/physical) ☐ Defiance/non-compliance ☐ Emotional Dysregulation </td> <td style="width: 50%; vertical-align: top; padding-left: 10px;"> ☐ Difficulty following directions ☐ Attachment Concerns ☐ Trauma Exposure ☐ Other: _____ </td> </tr> </table>			☐ Frequent tantrums ☐ Aggression (verbal/physical) ☐ Defiance/non-compliance ☐ Emotional Dysregulation	☐ Difficulty following directions ☐ Attachment Concerns ☐ Trauma Exposure ☐ Other: _____
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MH 774
7/1/2026

Safety & Risk Screening (check all that apply)

- | | |
|---|---|
| ☐ Harm to self | ☐ Severe caregiver-child conflict |
| ☐ Harm to others | ☐ If yes, please provide a brief note: |

Developmental/Clinical Considerations (check all that apply)

- | | |
|---|---|
| ☐ Attention Deficit Hyperactivity Disorder | ☐ Developmental Delays |
| ☐ Autism | ☐ Communication Concerns |
| ☐ Fetal Alcohol Spectrum Disorder | ☐ None/Unknown |
| ☐ Substance Exposure In-Utero | |

Current Services

Currently receiving therapy: ☐ Yes ☐ No
If so, please state treatment modality: _____
Diagnosis: _____
Telehealth appropriate? ☐ Yes ☐ No

Additional Referral Information (i.e special accommodations/accessibility needs etc)**If referring from a Contracted provider, please submit the following attachments with your referral:**

- | | | |
|---|--|---------------------------------------|
| ☐ Most recent clinical assessment/addendum | ☐ Progress notes (last 3 treatment notes) | ☐ Other: _____ |
| ☐ Needs Evaluation/CANS | ☐ Treatment Plan (if applicable) | |

Consent

- ☐ Caregiver informed of PCIT referral

For general questions or consultation, please contact LACPCIT@dmh.lacounty.gov