

Success Built on Strengths

Free Counseling for Individuals, Children, &
Families in West Louisville

Cardinal Success Program @ NIA



*We offer
parental support.*

We work with families.

*We support individuals
of all ages.*



Program Director:
Dr. Eugene Foster

Assistant Director:
Dr. Katy Hopkins

Call for more information or an appointment:

Cardinal Success Program @ NIA
2900 West Broadway
Suite 320
Louisville, KY 40211
502-852-3888

Graduate and doctoral students
at the University of Louisville,
College of Education and Human
Development provide counseling
and support services.



**CARDINAL SUCCESS
PROGRAM**

@ Nia Center

Cardinal Success Program @ NIA

Referral Form – Child/Adolescent

It is important that you communicate to the parent/legal guardian of the child/adolescent you are referring your concerns and explain this referral to them.

Name of referral source: _____

Referral source's phone number: _____

Date: _____

Name of child being referred: _____

Child's parent/legal guardian: _____

Parent/guardian's phone number: _____

How do you know the child (or parent/guardian of child) you are referring?

Have you talked to the child or parent/guardian about your concerns?

Have you talked to the child or parent/guardian about this referral?

What event or information prompted you to make this referral?

Thank you for making a referral! Please check off the items below to indicate the specific concerns of the child/adolescent you are referring.

- | | |
|---|--|
| <input type="checkbox"/> Suspected experience of abuse (physical, sexual, emotional) | <input type="checkbox"/> Impulsivity (reckless sex, impulsive buying, risk taking) |
| <input type="checkbox"/> Aggressive behavior | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Alcohol or drug use | <input type="checkbox"/> Legal problems (e.g., property damage, truancy) |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Excessive bed wetting/potty training issues | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> School concerns or difficulties | <input type="checkbox"/> Physical illness |
| <input type="checkbox"/> Custody of children | <input type="checkbox"/> Rage |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Runs away |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Sleeping problems (too much, too little, insomnia) |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Family difficulties | <input type="checkbox"/> Self-harming behaviors (scratching, banging head, cutting self) |
| <input type="checkbox"/> Eating problems (circle: overeating, undereating) | <input type="checkbox"/> Not speaking |
| <input type="checkbox"/> Excessive fears | <input type="checkbox"/> Social withdrawal |
| <input type="checkbox"/> Defiant to adults (oppositional, cursing, refusal to listen) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Grief | _____ |
| <input type="checkbox"/> Interpersonal conflicts | _____ |

Cardinal Success Program @ The Nia Center

Referral Form – Adult

It is important that you communicate to the adult you are referring your concerns and explain this referral to them.

Name of referral source: _____

Referral source's phone number: _____

Date: _____

Name of adult being referred: _____

Referred adult's phone number: _____

How do you know the person you are referring?

Have you talked to this person about your concerns?

Have you talked to this person about this referral?

What event or information prompted you to make this referral?

Thank you for making a referral! Please check off the items below to indicate the specific concerns of the adult you are referring.

- | | |
|--|--|
| <input type="checkbox"/> Suspected experience of abuse (physical, sexual, emotional) | <input type="checkbox"/> Impulsivity (reckless sex, impulsive buying, risk taking) |
| <input type="checkbox"/> Alcohol or drug use | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Marital/relationship conflict |
| <input type="checkbox"/> Career/school concerns, choices, or difficulties | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Decision making | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Parenting/custody difficulties |
| <input type="checkbox"/> Divorce or separation | <input type="checkbox"/> Rage |
| <input type="checkbox"/> Eating problems (circle: overeating, undereating) | <input type="checkbox"/> Poor self-care |
| <input type="checkbox"/> Excessive fears | <input type="checkbox"/> Sleeping problems (too much, too little, insomnia) |
| <input type="checkbox"/> Family conflicts | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Financial stressors | <input type="checkbox"/> Threatening violence to others |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Social withdrawal |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Physical illness | _____ |
| <input type="checkbox"/> Interpersonal conflicts | _____ |