

Mediation Referral



REFERRAL DATE:

COUNTY:

DISTRICT:

COURT CASE #: D- JQ-

CYFD FACTS #:

Type of Referral:

Court Ordered: yes no

Mediation Date:

TIME:

LOCATION:

Check Box if Applicable

Interpreter Required Language:

ICWA Contact information if known (name, #, email):

NMFAP Contact information if known, (name, #, email):

CHILDREN: (add additional children in case comment box)

Date Of Birth

Please provide all requested information if known. Use Case Information box if additional space is needed.

Respondent/Birth Parent 1

Phone Number:

Email Address:

Attorney for Respondent/Birth Parent 1

Respondent/Birth Parent 2

Attorney for Respondent/Birth Parent 2

Respondent/Birth Parent 3

Attorney for Respondent/Birth Parent 3

Respondent/Birth Parent 4

Attorney for Respondent/Birth Parent 4

Adoptive Parents/Guardians

Phone Number:

Email Address:

Attorney for Adoptive Parent/Guardian

Children's Court Attorney (CCA)

GAL/Youth Attorney:

CYFD Worker:

CYFD Supervisor:

CASA

Other Interested Parties:

ADDITIONAL CASE INFORMATION: (e.g. TPR petition filed, trial date set, Change of Plan, issues for mediation)

For CCMP Use

COMMENTS:

ASSIGNED MEDIATOR: