

# MEDIATION REFERRAL FORM

Please email this form to: [jdmed@contracosta.courts.ca.gov](mailto:jdmed@contracosta.courts.ca.gov)  
Or fax this form to: FAMILY AND INVESTIGATIVE SERVICES  
FAX (925)957-7984; TEL (925)957-7949

**THIS FORM NEEDS TO BE COMPLETELY FILLED OUT BEFORE E-MAILING OR FAXING!**

Case No.: \_\_\_\_\_ Dept. No.: \_\_\_\_\_

Case Name & Minor's Age: \_\_\_\_\_

Mediation Date: \_\_\_\_\_ Time of Mediation: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Place of Mediation (please check one):

- Pleasant Hill CFS Office (500 Ellinwood Way)     Richmond Courthouse     Antioch CFS Office  
 Other: (please specify) \_\_\_\_\_

Form Submitted By: \_\_\_\_\_ Caseworker: \_\_\_\_\_ Date of Next Hearing: \_\_\_\_\_

Are there DV allegations?  Yes  No    Is there a Restraining order?  Yes  No

Will client bring a support person to mediation?  Yes  No

Does client request separate mediation?  Yes  No

## MEDIATION PARTICIPANTS AND COUNSEL

Mother: \_\_\_\_\_ represented by: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Father: \_\_\_\_\_ represented by: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

DSS: \_\_\_\_\_ represented by: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Minor: \_\_\_\_\_ represented by: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

Other: \_\_\_\_\_ represented by: \_\_\_\_\_ Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

### Hearing Type:

- Jurisdiction  
 Disposition  
 Review

### Mediation requested by:

- Court     DSS  
 Mother     Minor  
 Father     Other

### Case Type:

- 300(a)     300(g)  
 300(b)     300(j)  
 300(c)

## STATEMENT OF SPECIFIC ISSUES TO BE MEDIATED:

- |  |   |
|--|---|
| <input type="checkbox"/> Language of Petition  | <input type="checkbox"/> Placement                |
| <input type="checkbox"/> Dispositional Arrangements                                  | <input type="checkbox"/> Counseling               |
| <input type="checkbox"/> Terms of Family Maintenance/Reunification Plan              | <input type="checkbox"/> Contents of Court Report |
| <input type="checkbox"/> Visitation  | <input type="checkbox"/> Drug Testing             |
| <input type="checkbox"/> Termination of Services                                     | <input type="checkbox"/> Availability of Services |
| <input type="checkbox"/> Other Issues or Limitations on the Matters to be Discussed: |   |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Please fill out the section below if an interpreter has been ordered:

Language: \_\_\_\_\_ For (mom, dad, etc.) \_\_\_\_\_

\*\*\*If an interpreter is needed for this mediation, the department hearing the matter needs to order the interpreter. Please make sure that an interpreter has been ordered before faxing this referral; Family and Investigative Services is NOT responsible for ordering an interpreter.