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| **Date of Referral**  | **Referral Source** | **Referral Contact #** |
|  |  |   |
| Referral Agency: |  | Agency #: |  |

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| --- | --- | --- |
| **Identified Youth’s Full Name** | **Date Of Birth** | **Gender** |
|  |  |  |
| Address: |  | Contact #: |  |
| Legal Guardian: |  | Contact #: |  |
| School: |  | Grade: |  |

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| **County Involvement** |
| CYF Caseworker: |  | Contact #: |  |
| CYF Supervisor: |  | Contact #: |  |
| JPO Officer: |  | Contact #: |  |
| JPO Supervisor: |  | Contact #: |  |

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| **Family Composition** |
| Female Caregiver: |  | Relationship: |  |
| History Of Substance Misuse, Abuse, Violence, or Mental Health Involvement? |  | Contact #: |  |
| CustodyArrangement: |  |
| Male Caregiver: |  | Relationship: |  |
| History Of Substance Misuse, Abuse, Violence, or Mental Health Involvement? |  | Contact #: |  |
| CustodyArrangement: |  |
| # of siblings/children in the home under the age of 18: |  |
| Other Supports: |  |
| Adolescent/Family Strengths: |  |

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| **Mental Health** |
| Diagnoses: |  |
| Medications: |  |
| Current Services: |  |

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| **Referral Criteria** |
| [ ]  **YES** [ ]  **NO** | The Identified Youth is under 18 years of age. |
| [ ]  **YES** [ ]  **NO** | The Identified Youth lacks or is in need of additional support services. |
| [ ]  **YES** [ ]  **NO** | The Identified Youth is currently involved with CYF and/or JPO. |
| [ ]  **YES** [ ]  **NO** | The Identified Youth is at risk for involvement with County Crisis, CYF, and/or JPO.  |
| **Areas of Risk:** | [ ]  Housing Instability[ ]  Verbal Aggression[ ]  Physical Aggression[ ]  Self-Harm | [ ]  Suicidal Ideation/Attempt[ ]  Conflict with Parents[ ]  Conflict with Siblings[ ]  Conflict with Peers | [ ]  Substance misuse[ ]  Criminal Activity[ ]  Runaway/Elopement[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Purpose for the Referral** |
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| **Additional Information** |
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**Next Section Only to Be Completed By CYF/JPO Staff.**

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| --- | --- | --- |
| **CYF/JPO Staff Member** | **Preferred Communication** | **Preferred Contact Information** |
| Name: | Cell / Office Phone / Email |  |
| **Date And Outcome of Referral Review** | **Is Further Review Necessary?** |
| Date Of Review:  ☐ Approved ☐ Denied  | ☐ Yes ☐ No |

\*If a meeting is needed to review the referral in more detail, please contact Brandon Amigh or Tessa McKay at Evolution Counseling, LLC. We will collaborate with the referral source to request and schedule a meeting.

Please Forward all decisions to: *Brandon Amigh, MS – FACE IT Program Director*

Email: bamigh@evolutionblair.com