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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 #: |  |
| Custody  Arrangement: |  |
| Male Caregiver: |  | Relationship: |  |
| History Of Substance Misuse, Abuse, Violence, or Mental Health Involvement? |  | Contact #: |  |
| Custody  Arrangement: |  |
| # 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