 Referral Form

 (Please Print or Type)

|  |  |  |
| --- | --- | --- |
| Date of Referral: |  – – (MM– DD– YYYY) | NC-JOIN ID: |
| Program: |   | County: |
|  |  |   |   |   |   |   |   |   |   |   |
| Client Name: |   | DOB: | SSN: XXX– XX–  | Gender: M [ ]  F [ ]  |
| Hispanic/Latino: [ ]  | Race: | School/Grade: |
| Legal Guardian Name/Relationship to Client: |   |
| Phone Number: |   | Guardian Phone Number: |
| Physical Address: | City: | Zip: |
| Mailing Address: | City: | Zip: |
|  |  |  |  |  |  |  |  |  |  |  |
| Is there Juvenile Justice Involvement? | Yes: [ ]  No: [ ]  |
| Is participation in this program court ordered? | Yes: [ ]  No: [ ]  |
| Is participation in this program a part of a diversion plan/contract? | Yes: [ ]  No: [ ]  |
| Court Counselor: | Phone: | Email: |
| Client Risk Score/Level: | Client Needs Score/Level: |
| **Current Legal Status:** | **Problem Behaviors/Risk Indicators:** |
| [ ]  NA/NO Juvenile Justice Involvement | **INDIVIDUAL** |   | **FAMILY** |   |   | **COMMUNITY** |   |
| [ ]  Bullying Behavior | [ ]  Excessive Dependence on Parents | [ ]  Availability or Perceived Access to Drugs |
| [ ]  Court Counselor Consultation | [ ]  Negative Labeling/Bullied | [ ]  Family Conflict |   |
| [ ]  Crime/Delinquency (Unreported and Reported) | [ ]  Lack of Discipline by Parent or Child is Ungovernable | [ ]  Disadvantaged/ Disorganized/Impoverished Neighborhood |
| [ ]  Diversion Plan/Contract |
| [ ]  Fighting/Assault/ Aggressive Behavior | [ ]  Siblings or Parent/Guardian on Probation or Incarcerated |
| [ ]  Petition Filed | [ ]  Feeling Unsafe in Home Neighborhood |
| [ ]  Deferred Prosecution | [ ]  Fire Setting | [ ]  Substance Use in Home |
| [ ]  Impulsive/Risk Taking | **SCHOOL** |  |   | [ ]  High Crime Rate in Home Neighborhood |
| [ ]  Adjudication Undisciplined Disposition Pending | [ ]  Mental Health Issues/ Depression/Anxiety/Temper Tantrums | [ ]  Academic Failure/Behind Grade Level for Age |
|   |  |   |
| [ ]  Behavior Problems: Disruptive in Class/Referrals to Office/Suspensions |   |  |   |
| [ ]  Adjudicated Delinquent Disposition Pending | [ ]  Poor Social Skills/Antisocial |   |  |   |
| [ ]  Run Away From Home | [ ]  Truancy/Skipping School |   |  |   |
| [ ]  Self-Mutilation | **PEER** |  |   |   |  |   |
| [ ]  Protective Supervision | [ ]  Sexually Active | [ ]  Gang Associate or Member; or Gang Involvement |   |  |   |
| [ ]  Sexual Offense |   |  |   |
| [ ]  Probation | [ ]  Sexual/Physical/Mental Abuse/Victimization/Trauma | [ ]  Negative Peer Associations/ Association with Aggressive Peers |   |  |   |
| [ ]  Commitment |   |  |   |
| [ ]  Post Release Supervision | [ ]  Substance Abuse (alcohol or drugs) | [ ]  Typically Associates with Negative Older Persons |   |  |   |
|   |  |   |
| [ ]  Continuation Services | [ ]  Suicide Attempts |  |  |  |   |  |   |
| [ ]  Suicidal Ideation/Threats |   |   |   |   |   |   |

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| **Additional Client Information:** |   |   |   |   |   |   |   |   |
| Does the Client Speak English? | Yes [ ]  | No [ ]  | What is the primary language spoken in the household? |
| Does the Client have an Exceptional Designation? (EC or IEP) | Yes [ ]  | No [ ]  |   |   |   |
| List any current medical problems: |   |   |   |   |   |   |   |
| List all current medications: |   |   |   |   |   |   |   |   |
| Does the Client have private medical insurance? | Yes [ ]  | No [ ]  | If Yes, Policy Number: |   |
| Does the Client have Medicaid/Health Choice? | Yes [ ]  | No [ ]  | If Yes, Policy Number: |   |
| If "no", has parent/guardian applied for Medicaid or Health Choice? | Yes [ ]  | No [ ]  |   |   |
| **Enter the number of problems the client has experienced over the previous 12 months:** |   |   |
| Number of Runaways |   |   | [ ]  Unknown |   |   |   |   |
| Number of Short-Term Suspensions |   | [ ]  Unknown |  |  |  |   |
| Number of Long-Term Suspensions |   | [ ]  Unknown |   |   |   |   |
| Number of Expulsions |   |   | [ ]  Unknown |   |   |   |   |
| **Additional Comments:** |
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|  |  |  |  |  |  |  |  |  |  |  |
| Name of Person Making the Referral: |   |   |   |
| Title: |   |   |   |   |   |   |   |   |   |   |
| Phone Number: |  |  |  |  |  |  |  |  |   |
| Email: |   |   |   |   |   |   |   |   |   |   |
| Describe the reason why you're referring this client to this program: |
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|
|
| Date the referral is received by the program: |  – – (MM– DD– YYYY) |   |