 Referral Form

(Please Print or Type)

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| 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) | | | | | | | | |  |