Service Coordination Referral Form

IDENTIFIED YOUTH **Date of Referral:** _____

Youth Name: _____ Date of Birth: _____

Social Security Number: _____ Sex: Female □ Male □ Race_____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Current School: _____ Grade: Regular Ed □ Special Ed □

Current diagnoses (check all that apply):

- □ ADD/ADHD
- □ ODD
- □ Bipolar
- □ Depression
- □ Autism/Asperger's
- □ Unknown
- □ Other:_____

PARENT/GUARDIAN INFORMATION

Name(s): _____ Relationship to Youth: _____

Home Address: _____ City: _____ Zip: _____

□ Check if same as above

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Hours: _____

# of Members in Household? _____

Sibling: Age: Sibling: Age:

_____ _____ _____ _____

_____ _____ _____ _____

Is youth at risk for placement out of the home? YES □ NO □
Is youth in need of transition/step-down services back to the community? YES □ NO □
Is youth/family in need of support and/or services to maintain the youth in the home/community? YES□ NO □
Referral is for: □ MST
□Service Coordination

Reason Referred for Services or Supports? _____

_____

_____

CURRENT YOUTH INVOLVEMENT
LAST 30 DAYS
(check all that apply)

- ☐ Juvenile Court
  - ☐ Detention
  - ☐ Probation
- ☐ DYS Parole
- ☐ Children Services
  - ☐ Investigation
  - ☐ Voluntary Case Plan
  - ☐ Custody
  - ☐ Protective Supervision
- ☐ Hospital
  - ☐ Medical
  - ☐ Mental Health-Psych
- ☐ DD
- ☐ Mental Health
  - ☐ Outpatient Counseling
  - ☐ Medication Management
- ☐ Substance Abuse Treatment
  - ☐ Outpatient
  - ☐ Inpatient
- ☐ Respite (out of home)

YOUTH CONCERNS/NEEDS

☐ Alcohol/Drug	☐ Child Abuse	☐ Child Neglect
☐ Delinquent	☐ Developmental Disabilities	☐ Mental Health
☐ Physical Health	☐ Poverty	☐ Special Education
☐ Unruly	☐ Other	☐ Other

Other

Agencies/Workers involved: (Name, Agency, phone number)

_____

_____

_____

Completed by: _____ Agency: _____ Phone: _____

*******Please attach a completed Risk Assessment form and signed Release of Information*******

For FCFC use only:

Date received: _____
Initial date of contact: _____
Date of assessment meeting: _____
Date of Family Team meeting: _____

Outcome of referral:

- ☐ SC case opened
- ☐ Referred elsewhere: _____
- ☐ Family refused services
- ☐ Unable to locate
- ☐ Other: _____