Connections for Families
Referral Form

Referral Source:

☐Service Review Team (SRT) ☐ Game Plan to Success (GPS)

Name of Person Making Referral:
Referral Agency:
Phone Number:
Email:

Child/Youth Name:	Date of Birth:	Age:
Parent Name:	Email:	
Home Address:	Home Phone:	
	Work Phone:	
	Other phone:	

FAMILY

Name	Role	Address (if different)

EDUCATION

School:	Grade:
Attendance History:	Suspensions:
Special Ed.? ☐ Yes ☐ No	If Special Ed., last IEP date:
If SIED, current placement/programming:	

LEGAL

Court Involvement? ☐ Yes ☐ No	If yes: ☐ D&N ☐ Delinquency ☐ PRNP
Adjudication Dates:	
Types of Adjudication: ☐ Property ☐ Person ☐ Sexual ☐ Other:	
Probation Officer:	ISP? ☐ Yes ☐ No
Date of Next Hearing:	PSI Complete? ☐ Yes (attach) ☐ No
Agency Involvement: ☐ SB94 ☐ Diversion ☐ DYC ☐ Other legal:	

SERVICE/PLACEMENT HISTORY

DSS Case #:	Caseworker:
Core Services: ☐ Outpatient MH ☐ Outpatient SA ☐ In-home MST ☐ Other: ☐ Sexual Offender Tx ☐ Intensive Family/Life Skills ☐ Day Treatment	

PLACEMENT	DATES OF CARE	LEVEL OF CARE (RTC, FC, GH, etc.)

CCAR completed for RTC?: ☐Yes ☐No If yes, Level of Function:

PSYCHIATRIC HOSPITALIZATIONS

FACILITY	DATES OF CARE	DIAGNOSIS	SERVICES PROVIDED

MEDICATIONS

MEDICATION	DATES/USAGE	RESULTS

PRESENTING PROBLEMS

☐ Arson History ☐ Assaultive ☐ Gang Activity ☐ Developmental Disability

☐ Sex Offender ☐ Teen Parent ☐ Court ☐ Substance Abuse

☐ Financial ☐ Family ☐ Animal Abuse ☐ Employment

☐ Peers ☐ Abuse Victim ☐ Medical MH ☐ Issues

☐ Other: ____

FAMILY STRENGTHS AND RESOURCES

REASON FOR REFERRAL

Attach Reports