

# YOUTH SERVICES TEAM

## REFERRAL INFORMATION

(To be completed by person making referral)

_____ Youth's Name	_____ Date of Birth	_____ Age	_____ Sex
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_____ Home Address	_____ Home Phone	_____ Work Phone
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_____ Referred By	_____ Representing Agency	_____ Date Referred
_____ School	Grade <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> IEP/504	Attending <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> At <input type="checkbox"/> Above <input type="checkbox"/> Below <input type="checkbox"/>

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Address (if different than above)

Father <input type="checkbox"/>	Mother <input type="checkbox"/>	Step Parent <input type="checkbox"/>	Foster Parent <input type="checkbox"/>	Adopted <input type="checkbox"/>	Other <input type="checkbox"/>
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\_\_\_\_\_  
Youth Lives With

Reason for referral:

\_\_\_\_\_

Family history and observations:

\_\_\_\_\_

Additional comments/information:

\_\_\_\_\_

Prior agency/YST involvement:

\_\_\_\_\_

Request for other agency participation in YST staffing:

\_\_\_\_\_