

SERVICE REQUEST AND REFERRAL

Referral Date (mm/dd/yyyy)	Type of Service AFTERCARE-ISS	County
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Other

Child / Juvenile Information

Name - Child / Juvenile		Birthdate (mm/dd/yyyy)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No
Address - Child / Juvenile (Street, City, State, Zip Code)		Telephone Number

Present Living Situation	
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Name - Present Care Provider

Name - School	Current Grade
<input type="checkbox"/> Yes <input type="checkbox"/> No Is this child / juvenile on Medical Assistance?	Medical Assistant Number

<input type="checkbox"/> Yes <input type="checkbox"/> No Does this child / juvenile meet criteria for severe emotional disturbance?

Teacher Information

Name (Last, First, Middle)	Birthdate (mm/dd/yyyy)	
Address (Street, City, State, Zip Code)	Telephone Number - Home	
Name - Employer	Is work contact permitted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone Number - Work

Parent Information

Name (Last, First, Middle)	Birthdate (mm/dd/yyyy)	
Address (Street, City, State, Zip Code)	Telephone Number - Home	
Name - Employer	Is work contact permitted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone Number - Work

Household / Family Members Information

Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship	Birthdate (mm/dd/yyyy)	Age
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			

Male Female

Male Female

Presenting Problem(s) of Child / Juvenile

Prior Services

- Individual therapy
- Family counseling
- Group therapy
- Intensive in-home
- Parent-aide
- Psychological evaluation
- Psychiatric evaluation
- Independent living
- Day care
- EMP
- UA / drug screening
- AODA evaluation
- AODA out-patient Tx
- AODA in-patient Tx
- Medication treatment
- Medication management
- Shocap
- Parenting classes
- Supervised visitation
- Community service
- Intensive supervision
- Transportation assistance
- Other specify:

Placement History

- Secure detention
- TFC
- Respite care
- Relative placement
- Chapter 51 in-patient
- Shelter home
- Foster care
- Group care
- Residential treatment
- Juvenile corrections

Additional Information

Family History

- Abuse / neglect
- Lack of supervision
- Parenting issues
- AODA issues
- Criminal behavior

- Additional Information

Educational / Social Background

- Truancy issues
- Failing grades
- Behavior problems
- Alcohol / drug use / abuse
- Ed programming
- LD programming
- Incomplete schoolwork
- Gang issues
- Poor social skills
- Delinquent peer group

Additional Information

Criminal History

- History of violence
- History of weapons
- Gang member / association
- Deferred prosecution agreement

Additional Information

Identified Needs / Areas of Concern

Strengths of Youth and / or Family

Additional Information

Supervisor's Comments



Signatures

SIGNATURE - Worker

Date Signed

SIGNATURE - Supervisor

Date Signed

