

**Referral for Services**

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| Today’s Date: |       |
| Client/Youth Name: |        | DOB:       | Age:       |
| School: |        | Grade:        | [ ] Male [ ] Female |
| Client’s Address: Street: City: Zip: |       |
|       |
|       |
| Phone: |       |
| Caregiver Information:•Check box of primary caregiver(s) •List name & relation | [ ]  Caregiver 1:       | Phone:       |
| [ ]  Caregiver 2:       | Phone:       |
| [ ]  Caregiver 3:       | Phone:       |
| Primary Language of Client: | [ ] English [ ]  Spanish [ ]  Other:       |
| Primary Language of Family: | [ ] English [ ]  Spanish [ ]  Other:       |
| Sibling Name/Relation: |       | Age:        |
| Sibling Name/Relation: |       | Age:       |
| Other Members in the Home: |       |
| Reason/Goals for Referral: |       |
|  |
| **Further Supporting information: (Check boxes)**[ ]  Basic Needs (housing, clothing, food, medical) [ ]  Transportation [ ]  Mental Health (general) [ ]  Life Skills (budgets, relationship skills, etc. [ ]  Housing [ ]  Suicidality/Self-Harm [ ]  Child Care & Early Education [ ]  Academic or Truancy [ ]  Symptoms of Psychosis[ ]  Employment & Job Training [ ]  Self-Esteem [ ]  Hyperactive/Impulsive [ ]  High Risk Behavior [ ]  Physical Aggression/Violence [ ]  Other:        |
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| **Current Service Providers for Client or Family** Agency Name Phone Dates |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|  |
| Referral Source:        | Contact Person/Relationship:       | Phone Number:       |

*\*\*\*\*Please send completed referrals to info@mywayfinder.org or call 970-328-8917.*

**For Office Use Only**

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| Trails #:       NOMS#:       Student I.D.#:       CCR#:      |
| Referral Received by:       Date:       |
| Date of Contact with Ct./Family:       Initial Contact made by:       |
| Date of Family Enrollment Acceptance:       |
| Unable to contact, enter date closure letter sent:       |
| Date Family Declined Services:       |