

**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: | |  | | | | | | |
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|  | | | | | | |
| 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: | |  | | | | | | |
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| **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 | | | | | | | | |
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| 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: |