YOUTH INTERVENTION REFERRAL FORM

REFERRAL SOURCE INFORMATION:

Referring Source/Agency: ____________________________ Date: ________________

Person Making Referral: ____________________________ Phone: _______________

YOUTH INFORMATION:

Youth Name: ____

Address: ____

School and Grade:____

Phone #:__________________________ DOB: _____________________________

Race/Ethnicity:____

Parent/Guardian Name: ____

Insurance Name and Policy:____

PARENT/GUARDIAN CONSENT – MUST be signed prior to referral being submitted

I have been given the Youth Intervention Program description and have requested to participate in the program.

I understand that I may be referred to other resources in the community for services.

I authorize Shiawassee Health and Wellness, Youth Intervention Specialist, to perform screening to identify signs of mental/emotional disturbance, distress, substance abuse issues and patterns of problem behavior.

I understand this authorization will expire on ____/____/____ *(not to exceed one year)* or upon termination of services.

I authorize the Youth Intervention Specialist to have verbal communication and/or send a follow-up letter regarding my child with (referral source):

____
(Print Referral Source Name)

______________________________________/____/___ ________________________________
Parent/Guardian Signature Date *Parent/Guardian Printed name*