Youth SERVICES

Referral/Intake Screening

Date/time ______________________ *YS Worker Name (if applicable):* ______________________

REFERRAL INFORMATION:	☐ Crisis hotline	☐ Walk-in	☐ Phone call	☐ Text	☐ Email	☐ Other:
Name of person needing services:		*DOB:*		*Age:*		
Legal name (if different)		*Preferred pronoun:*				
Race: *(Check all that apply)*	☐ **Decline to answer**	☐ Am. Indian or Alaskan Native	☐ Asian	☐ Black/African American		
☐ Native Hawaiian/Other Pacific Islander	☐ White / Caucasian	Are you Hispanic? ☐ Y ☐ N	Social Security #			

☐ ***You're making this referral for a friend or family member***	☐ **You're making this referral for yourself**
Your name (if not self)	
Your relationship to person being referred:	
☐ ***COMMUNITY PARTNER REFERRAL***	Name of agency/org. making referral:

☐ Medical professional ☐ Mental Health Professional ☐ School ☐ Parenting support agency ☐ Economic Services/Reach-up ☐ Housing support agency	☐ Police ☐ Probation ☐ DCF/Family Services ☐ Women's Freedom Center ☐ Court ☐ State's Attorney	☐ Substance Use Recovery ☐ Dept. of Labor ☐ Voc Rehab ☐ Prevention Coalition ☐ HCRS ☐ Other:	☐ Hospital/facility Name of hospital/facility: If hospital/facility, is there a discharge plan? ☐ Yes ☐ No **(please attach to referral)**

*Does the person being referred **know of referral**?*	☐ Yes ☐ No	*Does the person being referred know of **want services**?*	☐ Yes ☐ No

Contact information *(please provide as much information as possible)*			
Cell#:	**Home#:**	***OK to leave a message?*** ☐ Yes ☐ No	
How long until you're out of minutes/service?		**E-Mail:**	
Facebook messenger (if primary way to contact)		**Other Social Media Handle/s** (if primary way to contact)	
Address (if applicable):		**Mailing address** (if applicable)	
Town of residence:		**Other states you've live in:**	
Someone else we should contact if we can't get in touch with you?	Name:		Contact info:
Parent/guardian name (if under 18)	Name:		Contact info:
Please let us know if you have concerns about us possibly contacting your parent/s or guardian			
Previous client of Youth Services?	☐ **Yes** ☐ **No**	**Program/s & date/s:**	
Highest grade completed:		**Name of school:**	

Is there anything you want us to know immediately? (describe):			
Help us understand what supports you or the person wanting services/supports needs: (describe):			
Do you have any concerns for your/their safety?	☐ Yes ☐ No	*Has anyone else expressed concerns for your/their safety even if you disagree?*	☐ Yes ☐ No
Can you tell us more? (describe):			

Is this a mandatory requirement (i.e. court ordered): ☐ Yes ☐ No

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Do you have a timeline requirement for accessing services? *(ex: court ordered/72 hours, DCF family services requirement, etc.)*	☐ Yes ☐ No
What's the timeline, whose timeline is it, other details (describe):	

What do you need support with?

☐ No income ☐ Accessing resources ☐ Transportation ☐ Employment support ☐ Missing a lot of school ☐ Support to stay in school ☐ Re-enroll in school ☐ Getting insurance ☐ Driver's license ☐ Enrolling in college ☐ Connecting to community ☐ Finding healthy fun activities	☐ I left home as minor (runaway) ☐ Want to explore emancipation ☐ Currently nowhere to live ☐ Fleeing violence in home ☐ Risk of losing housing ☐ Kicked out of home ☐ Couch-Surfing ☐ Evicted ☐ Sleeping outside ☐ Legal issues ☐ Impending court date ☐ Recent ticket ☐ Charges I want to get wiped/dropped	☐ Help figuring out future ☐ No friends/feel lonely ☐ Depression ☐ Anxiety ☐ Managing anger ☐ Loss or death of significant person ☐ Scared/worried ☐ Feel unsafe ☐ Trauma history impacting life ☐ Thoughts of self-harming ☐ Thoughts of suicide ☐ Violent fantasies or thoughts about others	☐ Family conflict ☐ Relationship conflict ☐ Conflict/s with friends ☐ Being bullied/ganged up on ☐ Reconnect with family ☐ Pregnancy support ☐ Parenting support ☐ Life skills ☐ DCF Involvement support ☐ Substance use services ☐ Substance use residential treatment ☐ Substance use detox ☐ Concerns about someone else's ☐ Alcohol and/or drug use

Other (describe):

Can you tell us about what you checked and why? (describe):

Have you ever been involved with the following programs, services or systems?

Because discussing details can have a negative impact on pending legal cases/charges we will not be discussing specifics right now

Juvenile legal:	☐ Yes ☐ No	Name of program/service:	
Adult legal:	☐ Yes ☐ No	Name of program/service:	
DCF Family Services:	☐ Self ☐ Child ☐ Other	Dates & state/town (if known)	
Residential placement/program	☐ Yes ☐ No	Dates & state/town (if known)	

Other providers you're working with (therapist, social worker, parole, parenting, etc)

Name	Organization	Contact Info	
		Would you like us to contact them?	☐ Yes ☐ No
		Would you like us to contact them?	☐ Yes ☐ No
		Would you like us to contact them?	☐ Yes ☐ No

Friends, family, other supportive people in your life

Name	Relationship	Contact Information	
		Would you like us to contact them?	☐ Yes ☐ No
		Would you like us to contact them?	☐ Yes ☐ No
		Would you like us to contact them?	☐ Yes ☐ No

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		Would you like us to contact them? ☐ Yes ☐ No

Office use only:				
FOLLOW-UP TRACKING				
Coversheet:		ROIs		
Received by:		Date received		
Date	Action	Who	Next step	When