



Behavioral Health Services

Professional Partner Program

Referral Form

Date: _____ Has the family been informed of this referral? Yes No

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Phone: _____

County of Residence: _____

Date of Birth: _____ SSN: _____ Preferred Language: _____

Current Grade Level: _____ School: _____

Please indicate caregiver/contact person: _____

Address: _____ Phone: _____

Current Living Situation: Natural Home Foster Home Group Home Shelter Other: _____

Person and/or Agency referring: _____

Address: _____ Phone: _____

Please answer the following:

1) Is the youth a ward of the state? Yes No

2) Juvenile Justice Involvement or at risk of such involvement? Yes No

Please describe: _____

3) Is the youth currently failing all or most of his/her classes? Yes No

4) Is the youth truant from all or most of her/his classes? Yes No

5) Has the youth been diagnosed with a mental illness or behavior disorder? Yes No

If yes, please explain, include diagnosis and name of clinician: _____

6) Is the youth at risk of being removed from the home? Yes No

7) Does the youth demonstrate Inappropriate Sexual Behavior? Yes No

If yes, explain, include frequency: _____

8) Is the youth involved with drugs alcohol or other illegal substances? Yes No

If yes, explain, include frequency: _____

9) Does the youth demonstrate aggressive behavior? Yes No

If yes, explain, include type, physical or verbal, and directed towards whom, peers, parents, etc. Also, when, where, and other relevant circumstances: _____

10) Is the family interested in participating in Wraparound? Yes No

If Yes, Family will contact program Program will contact family

REQUIRED: Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE: Outcome of Referral: Screening Referral to Community Services