ALBANY YOUTH SERVICES TEAM
REFERRAL INFORMATION

(To be completed by person making referral)

Youth's Name | Date of Birth | Age | M ☐ F ☐ Sex

Home Address | Home Phone | Work Phone

Referred By | Representing Agency | Date Referred

School | Grade | IEP/504 ☐ Yes ☐ No | Attending ☐ Yes ☐ No | Academic Working Level ☐ At ☐ Above ☐ Below

Parent/Guardian Name

Address (if different than above)

Youth Lives With: Father ☐ Mother ☐ Step Parent ☐ Foster Parent ☐ Adopted ☐ Other ☐

15 min. pre-staff ☐ Time requested for staffing: ☐ 30 min. ☐ 45 min. ☐ 60 min. ☐

Reason for referral:

Family history and observations:

Additional comments/information:

Please Mark Previous Agency Involvement:

ABC House	☐	CSC	☐	LBL-ESD	☐	Sheriff	☐
Albany Fire Dept.	☐	DHS Child Welfare	☐	Mental Health	☐	YMCA	☐
Albany Police	☐	DHS Self-Sufficiency	☐	Oregon State Police	☐	Y-Mentor	☐
Alcohol and Drug	☐	Faith Community	☐	Parole & Probation	☐	Other:	
Boys and Girls Club	☐	Juvenile Dept.	☐	Relief Nursery	☐		

If you would like any other agencies to attend the meeting, please specify here: