YOUTH SERVICES TEAM

REFERRAL INFORMATION

(To be completed by person making referral)

Youth's Name | Date of Birth | Age | Sex

Home Address | Home Phone | Work Phone

Referred By | Representing Agency | Date Referred

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

Parent/Guardian Name

Address (if different than above)

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

Reason for referral:

Family history and observations:

Additional comments/information:

Prior agency/YST involvement:

Request for other agency participation in YST staffing: