LEBANON YOUTH SERVICES TEAM

REFERRAL INFORMATION

(To be completed by person making referral)

_____________________________________ _______________________ ____/____/____
Referred By Agency Date Referred

____ ___/___/___ _______ _______
Youth's Name DOB Age Gender

_______________________________________ ____________________ ____________________
Home Address Primary Phone Second Phone

_______________________________________ _____ IEP 504 Yes / No At / Above / Below
School Grade Accommodations Attending Academic Working Level

_____________________________________ ______________ __________________________________
Primary Caregiver's Name DOB (if applicable) Legal Custodial Parent/ Guardian)

_____________________________________ ______________
Primary Caregiver's Name DOB

Father Mother Step-Parent Foster Parent Adopted Sibling Other:____________________
Youth lives with (circle all that apply)

Reason for Referral: (What is needed from the team?)____
____
____
____
____

Family History and Observations: ____
____
____
____

Family Strengths/ Comments or additional information: ______________________________________
____
____

Mark Previous or Current Agency Involvement:

ABC House		CSC		Faith Community		Parole & Probation	
Alcohol and Drug		Development Dis.		Juvenile Department		Police	
Boys & Girls Club		DHS Child Welfare		LBL ESD		FT Relief Nursery	
CASA		DHS Self Sufficiency		Mental Health		Other	

Resources and Services Requested for Family:

Clothing Assist		Development Dis.		Mental Health		Social Skill Building	
Alcohol & Drug Assist		Health Care : Med./Dental/ Vision		Mentoring		Other	
Boys & Girls Club		Housing		Parenting Support		Other	
Food Resources		McKinney Vento		School Supplies		Other	

List Agencies/Caseworker that you are Requesting Participation in Staffing: _______________________