SHIAWASSEE Health & Wellness

YOUTH INTERVENTION REFERRAL FORM

REFFERAL SOURCE INFORMATION:

Referring Source/Agency: _____ Date: _____

Person Making Referral: _____ Phone: _____

YOUTH INFORMATION:

Youth Name (Print): _____
First Middle Last

Address: _____

School: _____ Grade: _____ Truancy Issues (circle): Yes or No

Youth DOB: _____ Youth Age: _____ Race/Ethnicity: _____

_____
Parent/ Legal Guardian's Name (Print) Email Address

Phone Number: _____ Insurance Name and Policy: _____

PARENT/LEGAL GUARDIAN CONSENT- MUST be signed prior to referral being submitted

I have been given the Youth Intervention Program description and have requested to participate in the program.

I understand that I may be referred to other resources in the community for services.

I authorize Shiawassee Health and Wellness, Youth Intervention Specialist, to perform screening to identify signs of mental/emotional disturbance, distress, substance abuse issues, and patterns of problem behavior.

I understand this authorization will expire on _____ (not to exceed one year) or upon termination of services.

I authorize the Youth Intervention Specialist to have verbal communication and/or send a follow-up letter regarding my child with (referral source):

_____
(Print Referral Source Name)

_____
Parent/Legal Gurdian Signature Date Parent/Legal Gurdian Printed name