ROCKLAND COUNTY PARTNERSHIP FOR SAFE & HEALTHY YOUTH

REFERRAL FORM

Partnership for Safe & Healthy Youth Center
131 North Midland Avenue, Nyack, NY 10960
Phone: (845)405-4180 **Fax**: (845)405-4199 **Email**: PSY@rboces.org

Referral Date:

Please send completed form and other pertinent assessments/evaluations via fax or email provided above.

YOUTH INFORMATION

Last Name:	First Name:	Birthdate:	Age:	Sex (at birth):
				M F

Is this their legal name?	If not, what is their legal name?
❑ Yes ❑ No ❑ Unknown	

Gender:
Male Female Non-binary Transgender
❑ Other: _____

Also known as:	Pronouns:

Ethnicity:
Hispanic or Latino: Yes No

If Yes:
- ❑ Central American
- ❑ Cuban
- ❑ Dominican
- ❑ Mexican
- ❑ Puerto Rican
- ❑ South American
- ❑ Other: _____

Street address:

City:	State:

Zip Code	Phone:

Race:
- ❑ Alaska Native
- ❑ American Indian
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White

Primary Home Language:

Insurance Coverage:	Insurance ID #:

FAMILY INFORMATION

PARENT / GUARDIAN / CARETAKER INFORMATION

(1) Last Name: First Name:	Phone (best contact number)
❑ Military Background	Email- ( )

Relationship to the above youth:
❑ Parent/Stepparent ❑ Guardian/Caretaker ❑ Kinship Foster Parent ❑ Foster Parent
❑ Residential Placement Caseworker ❑ Direct Family Placement

(2) Last Name: First Name:	Phone (best contact number)
❑ Military Background	Email- ( )

Relationship to the above youth:
❑ Parent/Stepparent ❑ Guardian/Caretaker ❑ Kinship Foster Parent ❑ Foster Parent
❑ Residential Placement Caseworker ❑ Direct Family Placement

HOUSEHOLD COMPOSITION		
Name:	**Age:**	**Relationship:**

REFERRAL INFORMATION

Agency Name:	**Referent's Name:**	**Phone:**
		Email-

Reason for Referral (Check as many as needed):

- ❑ Poor Peer Interaction
- ❑ Poor Academic Achievement
- ❑ Aggressive Behaviors
- ❑ Non-compliance at Home
- ❑ School Avoidance
- ❑ Current Services Insufficient
- ❑ Family Conflict
- ❑ Runaway
- ❑ DSS
- ❑ CPS
- ❑ Substance Use
- ❑ Gang Involvement
- ❑ Family Court Ordered
- ❑ Criminal Court Ordered
- ❑ Probation
- ❑ Hospital Discharge- Psychiatric
- ❑ Hospital Discharge- Substance Use
- ❑

Referral Narrative:

SERVICES INFORMATION

Past	Current		Past	Current	
❑	❑	**Welfare/Medicaid**	❑	❑	**Family Resource Center**
❑	❑	**Child Protective Services**	❑	❑	**Residential Placement**
❑	❑	**Foster Care**	❑	❑	**Probation Involvement**
❑	❑	**Family Court**	❑	❑	**Criminal Court**
❑	❑	**Case Management Services**	❑	❑	**OPWDD**
❑	❑	**SPOA Services**			

_____ **Number of Arrests**

_____ **Total # of days incarcerated**

SCHOOL INFORMATION

Home District:	**Current School:**	**Last School Attended:**
	❑ Home school ❑ Home instruction	❑ Home school ❑ Home instruction

Classified? Yes No	**Free or reduced lunch?**	**Current Grade**	**# of Absences in past 30 days**
Classification:	Yes No		
School Contact Name & Title:	Phone:	Email:	

Please attach current IEP and latest Re-evaluation Packet, if available

SCHOOL BEHAVIORAL INCIDENTS (To be filled out by school-based referents)

Please attach discipline report, if available

Current School Year	***Please indicate Number of occurrences***
0	Discipline Referrals
0	In School Suspension Incidents
0	In School Suspension Days (total per school year)
0	Out of School Suspension Incidents
0	Out of School Suspension Days (total per school year)
0	IDT Admissions

BEHAVIORAL HEALTH INFORMATION

Past	**Current**	**N/A**		
			Outpatient Mental Health Services	Provider: _____
			Inpatient Psychiatric Hospitalizations	Provider: _____
			Number of Hospitalizations: _____	Discharged: _____
			Outpatient Substance Abuse Treatment	Provider: _____
			Inpatient Substance Abuse Treatment	Provider: _____
			Witness to or first-hand experience of traumatic event	

Psychiatrist/Agency:	**Therapist/Agency:**	**Prescribed Medications:** ❑ Non-Compliant

DSM- V Diagnosis (please list all *current* diagnoses):

SERVICE PROVIDERS

Name:	**Agency/Title:**	**Phone #:**	**Email:**