



## Referral Form



From: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

Email: \_\_\_\_\_



One Referral Form Per Youth

Youth's Name: \_\_\_\_\_  
*First Middle Last*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Primary Caregiver or

Parents Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

**Reason for Referral:** ☐ School Engagement Concern ☐ Behavioral Concern  
☐ Family/Household Conflict ☐ Homeless/Runaway  
Check All That Apply ☐ Other: \_\_\_\_\_

### Other Needs/Priority Characteristics:

- |                                                                  |                                                   |                                                                          |
|------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Spanish Speaking Family                 | <input type="checkbox"/> Parenting Skills Concern | <input type="checkbox"/> Current/Former Military Connection              |
| <input type="checkbox"/> Current CPS Case Open                   | <input type="checkbox"/> Social Support Concern   | <input type="checkbox"/> Developmental Delay/Disability                  |
| <input type="checkbox"/> Past CPS Case <i>(dates below)</i>      | <input type="checkbox"/> High Stress Level        | <input type="checkbox"/> Mental Health Concerns <i>(indicate below)</i>  |
| <input type="checkbox"/> Referrals to Other Resources            | <input type="checkbox"/> Conflict at School       | <input type="checkbox"/> Substance/Alcohol Abuse <i>(indicate below)</i> |
| <input type="checkbox"/> Deferred Probation <i>(dates below)</i> | <input type="checkbox"/> Other: _____             |                                                                          |

Comments:

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Call, fax, mail, or email this referral to the Family and Youth Success Program at

**Phone: 903-753-9744 ★ Toll free: 866-782-7031 ★ Fax: 903-757-8294**

**Mail: P.O. Box 6800, Longview, TX 75608**

**Email: FAYS@CommunityHealthcore.com**