Youths Name: D.O.B & Current Age: Gender: Ethnicity:

Click or tap here to enter text.

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County of Residence: Address: Name of School & Grade:

Click or tap here to enter text.

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Guardian Name & Relation: Guardian Email: Guardian Phone #:

Click or tap here to enter text.

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Date of Referral: Referrers Name: Referrers Email:

Click or tap here to enter text.

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Agency Address: Agency Phone: Agency Email:

Click or tap here to enter text.

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Others Living in the Home Relationship to Youth Gender

Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.

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Reason for Referral/Description of problems being experienced:

Click or tap here to enter text.

Private Insurance

Name: Click or tap here to enter text.Member ID#: Click or tap here to enter text.

Medicaid Name: Click or tap here to enter text.Member ID#: Click or tap here to enter text.

Waiver Yes  No

Other: Click or tap here to enter text.

Youths Social Security #: Click or tap here to enter text.

Diagnosis:

Click or tap here to enter text.

Medications: (Name/Milligrams/# of Times a day/Pill or Capsule)

Click or tap here to enter text.

Problem Behaviors:

Personal hygiene Irritability Probation/Parole

Loses Temper Easily Lying Destruction of Property

Stealing Verbally Aggressive Cruelty to Animals

Physically Aggressive Poor Social Skills Self-Harm Behavior

Low Self-Esteem Family Functioning Thought Disturbances

AWOL Enuresis Encopresis

Anxiety Grief Separation/Loss

Fire Setting Discipline School attendance

School Problems Failure to Supervise Poor Household Management

Addiction (gambling, etc.) Mood Swings Employment Problems

Depressed Mood Substance Abuse Suicide Ideation/Gestures

Sexual Perpetrator Sexually Reactive Sexually Promiscuous

Victim of Sexual Abuse Victim of Physical Abuse Easily Distracted

Hyperactive Impulsivity Domestic Violence

Inflated Self-Esteem Hallucinations Relationship Difficulties

|  |  |  |  |
| --- | --- | --- | --- |
| Current & Past Agencies Involved with Youth/Family | Provided Services  Check which applies | Representative Involved Name and Contact Info | Reason for  Involvement |
| Click or tap here to enter text. | Open Case  Closed Case | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Open Case  Closed Case | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Open Case  Closed Case | Click or tap here to enter text. | Click or tap here to enter text. |

**Send Referrals by Email or Fax:** [**morrowfcfc@gmail.com**](mailto:morrowfcfc@gmail.com) **F: 419-617-1882**

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**Office Use Only:** Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recommend: Referral\_\_\_\_ Service Coordination\_\_\_\_

Meeting Location and Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_