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 ServicesCheck which applies | Representative Involved Name and Contact Info | Reason forInvolvement |
| 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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**Send Referrals by Email or Fax:** **morrowfcfc@gmail.com** **F: 419-617-1882**

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

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