

With Friends Youth Shelter Referral Worksheet

Emergency Shelter Transitional Living Program Today's Date: ___/___/___ Time: ___:___ AM PM

General Information

Client's Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ Sex: Male Female County: _____
Parent/Legal Guardian: _____ Phone: _____ Cell: _____
Parent/Legal Guardian: _____ Phone: _____ Cell: _____
Referring Agency: _____ Phone: _____ Cell: _____
DSS Social Worker: _____ Phone: _____ Cell: _____
DJJ Case Worker: _____ Phone: _____ Cell: _____

Medical Information

Does client have health insurance? Yes No If yes, type: _____
Is client on medication? Yes No If yes, list: _____
If no, previously on medications? Yes No If yes, list: _____
Does the client have problems taking the medication? Yes No If yes, why: _____
Does the client have any diagnosis? (ADHD, ADD, ODD, PTSD, Autistic, Asperger, Mild MR, MR, etc.) Yes No
If yes, list: _____
Psychologist/Therapist/Counselor: _____ Phone: _____ Cell: _____
Does the client have any allergies to general items, food, or medication? Yes No
If yes, list: _____
Does the client have any medical conditions? (Diabetes, Epileptic Seizures, Communicable Diseases, etc.) Yes No
If yes, list: _____

Education Information

Is the client enrolled in school? Yes No If yes: Elementary Middle High GED College
Name of the school: _____ Grade: _____
If no, please explain: _____
Is the client currently suspended or expelled? Yes No
If yes, please explain: _____
Is the client having issues at school? Yes No
If yes, please explain: _____

Program Information

Is the client court involved? (DSS/DJJ) Yes No
Is the family homeless or doubled-up? Yes No
Is the client RHY? (Runaway, Homeless, Doubled-up, Throwaway) Yes No
Is the client gang affiliated? Yes No
Does the client have a history of drugs or alcohol use? Yes No
Does the client have a history of violent or assaultive behavior? Yes No
Does the client have a history of criminal offenses/delinquency? Yes No
Does the client have a history of sexual assault or misconduct? Yes No
Has the client ever been placed outside of the home? Yes No

Client Documentation

Birth Certificate
Court Orders
Social Security Card
Insurance Card
Shot Records
Medical Records
State ID/License
HSD/GED
Employed

Reason for referral: _____

Review Needed Date: _____ Outcome: _____ Employee INT: _____
Review Needed Date: _____ Outcome: _____ Employee INT: _____

Accepted Denied If denied, why: _____

Bed Available? Yes Intake Appointment Date: _____ Time: ___:___ AM PM
No Waiting List