CHJC Human Services & Community-Based Programs

Community School Liaison Program Intake/Referral Form

Send information to: mliede@chjc.org

Direct: (315) 777-9127

Fax: (315) 779-1184

Date of Referral:

Referral Contact Information

NAME:

NUMBER:

ORGANIZATION: ☐ N/A

EMAIL:

BEST TIME TO CONTACT:

RELATIONSHIP TO YOUTH:

Demographic Information

CHILD'S NAME: (Last) (First) (M)

DATE OF BIRTH: GENDER: RACE:

LAST KNOWN ADDRESS: (Street) (Apt. Number)

(City) (State) (Zip) (County)

Educational Information

CURRENT/LAST SCHOOL ATTENDED: GRADE LEVEL:

CONTACT PERSON: NUMBER:

IEP: ☐ YES ☐ NO CLASSIFICATION:

Presenting Problems/Concerns

Express concerns and presenting problems:

_____

_____

_____

Has youth displayed any of the following behaviors in the last six months:

☐ Aggression	☐ Developmental Disability	☐ Sexual Offense
☐ Assault	☐ Drug/Alcohol Use	☐ Suicide Attempt
☐ AWOL	☐ Fire Setting	☐ Theft
☐ Brain Injury	☐ History of Out of Home Placement	☐ Trauma
☐ Cruelty Toward Animals	☐ Indiscriminate Sexual Behaviors	☐ OTHER

Please explain:

_____

_____

_____

Parent/Caretaker/Guardian Information

PRIMARY CARETAKER:

RELATIONSHIP TO YOUTH:

CONTACT INFORMATION:

Number:

Email:

Address: ☐ Same as youth

Best Time to Contact:

ALTERNATIVE/SECONDARY CARETAKER (if applicable):

RELATIONSHIP TO YOUTH:

CONTACT INFORMATION:

Number:

Email:

Address: ☐ Same as youth

Best time to contact:

Insurance Information

INSURANCE COMPANY:

POLICY HOLDER NAME: POLICY NUMBER:

If Medicaid, please include Sequence Number:

Medical Information

PRIMARY CARE PROVIDER: NUMBER:

PSYCHIATRIC DIAGNOSIS (list all):

PSYCHIATRIST: NUMBER:

DATE OF LAST EVALUATION: _____

CURRENT MEDICATIONS:

NAME	DOSAGE	FREQUENCY	START DATE

Current Service Providers (if applicable)

NAME	AGENCY	NUMBER	START DATE