Community Partnership for Children
protecting children . . . fostering family stability

Supportive Trusting Relationships with Inclusion, Vision, and Empathy (S.T.R.I.V.E)

Referral Form

Youth Demographic Information					
Case Name in FSFN:	**Case Number in FSFN:**				**Date of Referral:**
Name of Youth Referred #1:	DOB:	Gender:	Race:	Ethnicity:	Date of Removal:
Permanency Goal:	Date of Reunification:			Current Placement:	
Current School and Grade Level:	Progress:				
Address:		City:			Zip:
Contact Number:					
Name of Youth Referred #2:	DOB:	Gender:	Race:	Ethnicity:	Date of Removal:
Permanency Goal:	Date of Reunification:			Current Placement:	
Current School and Grade Level:	Progress:				
Address:		City:			Zip:
Contact Number:					
Name of Youth Referred #3:	DOB:	Gender:	Race:	Ethnicity:	Date of Removal:
Permanency Goal:	Date of Reunification:			Current Placement:	
Current School and Grade Level:	Progress:				
Address:		City:			Zip:
Contact Number:					
Name of Youth Referred #4:	DOB:	Gender:	Race:	Ethnicity:	Date of Removal:
Permanency Goal:	Date of Reunification:			Current Placement:	
Current School and Grade Level:	Progress:				
Address:		City:			Zip:
Contact Number:					
Parent Demographic Information					

Mother:

Address: City: Zip:

Contact Number: Alt. Phone Number: Best Time to Contact:

Contact Email: Primary Language Spoken:

Father:

Address: City: Zip:

Contact Number: Alt. Phone Number: Best Time to Contact:

Contact Email: Primary Language Spoken:

Guardian Demographic Information

Guardian/Caretaker #1: Relationship to Youth:

Address: City: Zip:

Contact Number: Alt. Phone Number: Best Time to Contact:

Contact Email: Primary Language Spoken:

Guardian/Caretaker #2: Relationship to Youth:

Address: City: Zip:

Contact Number: Alt. Phone Number: Best Time to Contact:

Contact Email: Primary Language Spoken:

Referral Source

Name and Agency: Contact Number: Fax: Email Address:

Supervisor Name: Contact Number: Fax: Email Address:

Agencies Youth/Family Are Involved With

☐ Mental Health Agency/Clinic/Provider Contact Information: _____

☐ Child Welfare/Child Protective Services Contact Information: _____

☐ Physical Health Cre Agency/Clinic/Provider Contact Information: _____

☐ Family Court Contact Information: _____

☐ Substance Abuse Agency/Clinic/Provider Contact Information: _____

☐ Juvenile Court/Corrections/Probation/Police Contact Information: _____

☐ Intellectual Disabilities Agency/Clinic/Provider Contact Information: _____

☐ School/Educational Facility/Staff Contact Information: _____

☐ Early Intervention Contact Information: _____

Other: _____ Contact Information: _____

Reason for Referral (Check all that apply):

☐ Behavior/Conduct ☐ Emotional ☐ Mental Illness ☐ Employment Instability ☐ Legal/Probation/Court Mandated

☐ Social/Interpersonal Challenges ☐ At Risk ☐ Substance Use/Abuse ☐ Domestic Violence ☐ Educational Instability/Challenges

☐ Family Conflict ☐ School Behaviors ☐ Grief/Loss ☐ Trauma ☐ Persistent Non-Compliance

☐ Self-Injurious Behavior ☐ Adjustment Related Issues ☐ Abuse/Neglect ☐ Other: _____

Symptoms and Behaviors of Risk: (Check all that apply):

☐ Anxiety/Panic ☐ Adjustment Challenges ☐ Depressed Mood ☐ Psychotic Features ☐ Suicidal Ideations/Attempts

☐ Homicidal Ideations/Attempts ☐ Isolative Behaviors ☐ Hyperactivity ☐ Manic Mood ☐ Impulsivity ☐ Physical Aggression

☐ Verbal Misconduct ☐ Unlawful Activity ☐ Self-Care Deficit ☐ Social Withdrawal ☐ Obsessions/Compulsions

☐ Physical Pain/Discomfort ☐ Changes in Sleep Patterns ☐ Changes in Appetite ☐ Excessive Worry/Fear ☐ Grief ☐ Changes in Behavior

☐ Lack of Motivation ☐ Inattentive ☐ Poor Self-Image/Confidence ☐ Defiant ☐ Academic Challenges ☐ Change in Work Habits

☐ Excessive Crying Tantrums ☐ Separation Problems ☐ Attachment Problems ☐ Running Away

☐ Other: _____

Please Discuss Presenting Problem:

Desired Outcome for Services

Youth and Family Strengths

Youth and Family Informal Supports (ex: Relatives, Community Organizations, Schools)

Other Notes:

Referral to Include: (Please attach)

☐ Social History ☐ Any Psychological/Mental Health/Substance Abuse Evaluation ☐ School Records

☐ Safety Plan ☐ Case Plan ☐ CBHA

☐ Other: _____

S.T.R.I.V.E Administrative Use Only

☐ Review Referral Date and Time Received: Date Completed:

☐ Initial Case Review/Staffing Date Completed:

☐ Eligibility Form Completed Date Completed: Referral Accepted for Services: ☐ Yes ☐ No

☐ Family Partner Assigned: Date of Initial Face to Face Meeting with Family:

_____

BAYS S.T.R.I.V.E Staff Printed Name

_____

BAYS S.T.R.I.V.E Staff Signature

_____

Date

Questions or to make a referral call: S.T.R.I.V.E (386) 222-0434
Email Referral and/or attached documents to: BAYS-STRIVE@bayskids.org