Referral Form

Child/Youth's Name: ______________________________ **Date of Birth:** ____________

Age: ______ **Gender:** Male ☐ Female ☐ **Date of Referral** ____________________

Referral Source Name: ____________________ **Phone Number:** ____________________

Referral Source Code: (Please check applicable box):

Person County DSS	☐	Foster Family	☐	Triumph	☐	Parent	☐
Social Service Agency	☐	Relative	☐	Police	☐	School	☐
Department of Corrections	☐	Clergy	☐	Court	☐	Substance Abuse Agency	☐
Freedom House	☐	Friend	☐	Residential Facility	☐	Other	☐
Juvenile Court	☐	Private Provider	☐	Youth Villages	☐	Family	☐
Probation or Parole	☐						

Child's Ethnicity (Please check applicable box):

Central American	☐	Korean	☐	Bi-Racial	☐	Cuban	☐
South American	☐	Laotian	☐	Asian Indian	☐	African American	☐
Cambodian	☐	Thai	☐	Puerto Rican	☐	Portuguese	☐
Chinese	☐	Vietnamese	☐	Mexican	☐	Dominican	☐
Hispanic	☐	Other	☐				

Child's Race (Please check applicable box):

White	☐	Black	☐	Asian American	☐	Native American	☐	Pacific Islander	☐

Child/Youth/Family Residing Address:

Street Address (physical address):		
City:	State:	Zip Code:

Child's Current Living Arrangement (Please check applicable box).

Unknown	☐	Residential Treatment Facility	☐
With either or both parents	☐	Hospital in Community (Psychiatric Unit)	☐
With relative other than parent	☐	Hospital in Community (Medical)	☐
Foster home in the community	☐	Psychiatric Hospital	☐
Foster home outside the community	☐	Homeless	☐
With family friend or friend	☐	Group Home	☐
Family homeless shelter	☐	Other	☐

School	Grade:	Special Ed: yes ☐ no ☐	IEP: yes ☐ no ☐	School Phone:

Parent(s) Guardian Name: ____

Parent(s) Address: ____

Phone: (Home)__________________ (Work) __________________ (Cell)______________

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Email Address: ____

the biological parent the legal guardian? Yes ☐ No ☐
If no, who is? ____

Family Type (Please check applicable box)			
Emancipated	☐	Adoptive Family Two Caregivers	☐
Biological Family Two Caregivers	☐	Adoptive Family One Caregiver	☐
Biological Family One Caregiver	☐	Relative and/or Guardian Care Two Caregivers	☐
Foster Family Two Caregivers	☐	Relative and/or Guardian Care One Caregiver	☐
Foster Family One Caregiver	☐	None of the above	☐

Primary Language Parent (Please check applicable box):
English ☐ Spanish ☐ Other European ☐ Asian ☐ African ☐

Primary Language Child (Please check applicable box):
English ☐ Spanish ☐ Other European ☐ Asian ☐ African ☐

Please check all that apply:
Child lives with: Mother ☐ Father ☐ Other ☐ (Specify)

Other relevant family members/persons in household	Relationship	Age	School	Grades

Presenting Problem (Check all that apply)

Mental Health Issues	☐	Welfare	☐	Domestic Violence	☐	Child Custody	☐	Parenting Issues	☐
School Issues ☐	☐	Employment	☐	Child Abuse & neglect	☐	Guardianship	☐	Other	☐

Please provide brief narrative that addresses your specific reason for referral, areas of concern, personality traits of parents and children, family dynamics observed, and strengths identified.

____

____

____

Are there any mental health diagnosis? Yes ☐ No ☐ If answered yes, please list below.

____

Are there any physical disabilities? Yes ☐ No ☐ If answered yes, please list below.

____

roots and wings
helping families be families

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Service Providers- Current and Previous

Dates	Name	Agency	Number

Please note child's functional impairment/strengths in relation to: (Please check all applicable reasons for referral below.)

Suicidal Ideation	☐	Witness of Physical Assault	☐	Sleep Disturbance/ sleep disorder	☐	Being expelled from School	☐
Suicidal Attempts/gestures	☐	Victim of Physical Assault	☐	Severe Sibling conflict	☐	Eating Disorder	☐
Depressed	☐	Victim of other violent crimes	☐	Police Contact	☐	Alcohol Abuse	☐
Self Mutilation	☐	Pregnancy of Child	☐	Property Damage	☐	Marijuana Abuse	☐
Self injurious behavior	☐	High Risk Behavior	☐	Theft	☐	Delinquent Activities	☐
School Phobia	☐	Relocation of family	☐	Threat to life of others	☐	Attentional Difficulties	☐
Suspension from School	☐	Peer problems	☐	Extreme verbal abuse	☐	Other problem not listed	☐
Expulsion from Schoo	☐	Running Away	☐	Truancy	☐	Oppositional Behavior	☐
Eating Disorde	☐	Sexual Acting Out	☐	Academic Problems	☐	School Refusal	☐
Alcohol Abuse	☐	Fire Setting	☐	Sexual Offending by Client	☐	Severe parent-child conflict	☐
Marijuana Abuse	☐	Sexual Abuse by Client	☐	Non compliance	☐	Severe mental illness	☐

Please check services desired:

Parenting Class (offered 3 times per year- January, April, September)	☐	Family Advocacy	☐
Tutoring Services	☐	Friday Night Out	☐
Mentoring	☐	Other Please explain if you mark this box.	☐

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SIGNATURE OF PARENT/GUARDIAN IS REQUIRED FOR PROCESSING

I understand that my signature gives the referring agency permission to share the above information necessary for the referral with *roots & wings*. I understand that this information will be used to determine services provided and the best practice to utilize.

Signature of Legal Guardian ____

Date: ____________________________________

Mail or fax completed referral to:

roots & wings
Attn: Director or Family Advocate
1200 North Main Street
Roxboro, NC 27573
(336) 322-5437 or Fax (336) 322-5439
Email address: rootsandwings@esinc.net

This form can also be found on our website at
rootsandwingsofpc.org