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| **Divine Youth Wellness Centre, LLC 6506 Wright Way, St. Louis, MO 63121** (p) 314-643-6621  (e) intake@divineyouthwellnesscentre.com  (w) www.divineyouthwellnesscentre.com | **Please fill out form completely** -Write N/A if unknown -Submit all required pages -Return completed form to office/confidential email |
|  |  |

**CONFIDENTIAL YOUTH ENROLLMENT REFERRAL FORM**

**Referred by:** **School** **Parent/Guardian**

**Agency** **Court**

**Hospital****Other:** \_         

     

**Source of Referral’s Name:**       **Source of Referral’s Title: ­­­­­**\_        

**Address:**     **Work Ph. (**     **)****Cell Ph. (**     **)**

**Details of Referred Youth:**

**Youth’s Name:**      **DOB:**     **/**     **/**     **Age:**     

**Address:**      **Relationship to youth:**      

**Parent/Guardian Name:**                **Phone:** **(**     **)**      **Mob:** **(**     **)**      

**(First) (Last)**

**Email:**     

**Ethnic origin: Please specify your ethnicity**

White  Hispanic or Latino

Bi-Racial/Multiracial:           Black or African American  Native American or American Indian  Asian / Pacific Islander  Non-Hispanic  Other:

Youth Doesn’t Know

**Education: What is the youth’s current school level?**

No schooling completed   Preschool/Pre-K: Specify:         Grades 1-5: Specify grade:          Grades 9 to 12: Specify Grade:              Some high school, no diploma  Other: Specify:

**Gender:**

Male  Female

Trans Female (MTF or male to female)  Trans Male (FTM or female to male)

Cisgender  Prefer not to answer

Other: \_\_     \_\_  Cisgender

**Sexual Identity:**

Heterosexual  Unsure

LGBTQIA+: Specify      \_  Prefer not to answer

Other:      \_\_\_\_

**Basic Issues: (check all that apply)**

Child Protection Services /Orders Youth Justice Involvement/Orders

Case Plan (obtain from Youth Justice/Child Services)

Current support needs:

Risk of harm and protective factors:

Are there Family and Supports in place? Y/N If yes, please list:

School Issues:

Mental /Health Issues:       

Disability

Other:

**Housing Status:** (Sleeping rough, unstable, temporary housing, homeless):

**Consent obtained from young person if age appropriate** **Yes** **No**

**Other services or persons involved (Please list):**                 

**Reason(s) for Referral- Problems/Concerns/Other related to: (Please check all that apply.)**

Dramatic change in behavior  Cries easily for age  Self-image/confidence

Worries  Non-touchable/pulls away   Nervous/anxious

Perfectionist  Daydream/fantasizes  Aggression/Anger

Swearing  Fighting  Hurts self

Impulsive  Grief  Lying/dishonesty

Bullying  Disrespectful  Defiant

Overactive  Easily distracted   Fears

Chews (paper/clothes/hair  Makes Odd Sounds  Stealing

Destruction of Property  Sadness  Sexual Acting Out

Physical abuse  Neglect  Abandonment

Sexual Abuse  Peer Relationships  Social Skills

Absences  Personal Hygiene  Always tired/restlessness

Personal Hygiene  Family Concerns  Academics

Absences  Tardiness or Truancy   Motivation

Inattentive  Withdrawn  Work habits/organization

Emotional or psychological abuse  Drop out risk (H.S.)

Incompletion of Assignments/Homework  Nightmares/night terrors

Other:        Only Social Activities(No

Concerns)

**Clarify Referral Reason or Concerns(Problem):**

**ACTIONS taken by the person referring this youth, if applicable: (list any interventions attempted):**

Have you contacted parent/guardian about your concern? Yes Date: Click or tap to enter a date.

No  Explain below the outcome of parent contact:

**What other services is youth (behavioral health services, receiving counseling, recreational activities, etc****.)?**

**Youth’s current likes, strengths, and activi****ties?**

**Additional Information, if applicable:**

**Referral for Membership Department: (Please check all that apply)**

In-Office: Play-Based Individual Therapy

In-Office: Social Skills @ Play

On-Site: SEM-Care (Small Social-Emotional Educational Groups)

**--------------------------------------------------Below is for the office use only-----------------------------------------------**

Name of person completing referral \_\_             \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date received referral ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Referral was confirmed with referrer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral form put into folder.

Inappropriate Referral/referral on to\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_