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| **Divine Youth Wellness Centre, LLC6506 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\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_