**Cater 2 You Youth Haven**  
**Youth Referral Form**  
45 Long Lane, Upper Darby, PA 19082  
**referrals@cater2youyouthhaven.org** | 484-466-3023

**REFERRING AGENCY INFORMATION**

* **Agency Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Agency Contact Person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **County of Jurisdiction:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Referral:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_

**YOUTH INFORMATION**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Preferred Name/Nickname (if any):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_
* **Age:** \_\_\_\_\_\_
* **Gender Identity:** ☐ Male ☐ Female ☐ Non-binary/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_
* **Preferred Pronouns:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Race/Ethnicity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Is the youth currently in foster care?** ☐ Yes ☐ No
* **Legal Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Guardian Contact Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL/MENTAL HEALTH INFORMATION**

* **Is the youth prescribed medication?** ☐ Yes ☐ No  
  If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Any known allergies or medical conditions?**
* **Behavioral health diagnosis (if applicable):**
* **History of substance use or current treatment involvement?**  
  ☐ Yes ☐ No — If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Is the youth receiving therapy or psychiatric care?**  
  ☐ Yes ☐ No — Provider Name/Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LEGAL & PLACEMENT DETAILS**

* **Legal Status:** ☐ Dependent ☐ Delinquent ☐ Shared ☐ Other: \_\_\_\_\_\_\_\_\_\_
* **Current Placement Type:** ☐ Foster Home ☐ Shelter ☐ Residential ☐ Kinship ☐ Other: \_\_\_\_\_\_\_\_\_\_
* **Reason for Referral to Cater 2 You Youth Haven:**

**EDUCATIONAL STATUS**

* **Current School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **IEP or 504 Plan in Place?** ☐ Yes ☐ No
* **Last Grade Completed:** \_\_\_\_\_\_\_\_\_\_
* **Special Education Needs:** ☐ Yes ☐ No – If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_

**SERVICE NEEDS & GOALS**

* What are the youth's service needs or desired program goals?  
  ☐ Emergency Housing  
  ☐ Life Skills Training  
  ☐ Mental Health Support  
  ☐ Job Readiness/Employment  
  ☐ Education Support  
  ☐ Medical/Dental Coordination  
  ☐ Conflict Resolution / Behavior Management  
  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL NOTES / CONSIDERATIONS**

* **Does the youth have any known triggers or safety concerns?**
* **Is the youth a danger to self or others?** ☐ Yes ☐ No – If yes, explain:
* **Any history of AWOL (runaway behavior)?** ☐ Yes ☐ No
* **Any pending court dates or legal obligations?** ☐ Yes ☐ No – If yes, list dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE**

By submitting this referral, the referring agency affirms that all information provided is accurate to the best of their knowledge.

**Referring Worker’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_  
**Supervisor’s Name & Contact (if applicable):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_