CONNECTIONS
INCORPORATED

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SERVICE REFERRAL

(Please complete as much as possible to assist with initial planning.)

Date of Referral:	
Participant Name:	
Date of Birth:	**Age:**
Primary Address:	
Presenting Needs	
Referring Individual and reason for referral:	
Youth or young adults' description of any needs or challenges:	
Family/Guardian/ Youth perceptions of any needs or challenges:	
Living Situation	
Self/Parent's Home ☐ Rent ☐ Own	****Residential/Treatment Facility** ☐ Hospital ☐ Temporary Housing ☐ Residential Care
****Other** ☐ Friend's Home ☐ Relative's/Guardian's Home ☐ Foster Care ☐ Detention/ Prison ☐ Homeless ☐ Homeless/Emergency Shelter ☐ Other:	
****Identify Facility or person's name with whom the participant lives./ Contact Information:**	
Secondary Street Address (if different from current address listed at top of form or permanent address if in transition)	
Youth or young adults' custody status or parenting plan (if applicable) Who is legal guardian? ☐ Emancipated/ Own legal guardian ☐ Youth lives with a parent (biological or adoptive) in same household ☐ Other (describe):	
Social Information	
Strengths/Capabilities (include strengths, skills, and abilities relevant to participants' functioning):	
Religion/Spirituality/ Cultural/ Ethnic/ Language Needs:	
Academic History	
Currently attending: ☐ No ☐ Yes	If currently attending, name of school/institution:
If NOT currently attending, highest level of education:	If currently attending, current grade/year:
Did/Do You Attend Special Education Services? ☐ No ☐ Yes	
Employment History	
Currently Employed? ☐ No ☐ Yes If yes, name of employer and job title:	
Employment History (to include employment gaps, history of being fired, previous employment, etc.)	
Employment Interests/Skills/Concerns (to include coworker interactions, career aspirations, etc.)	

CONFIDENTIAL: Contains protected health care information. Distribution authorization required

Legal History

Legal Status
☐ None Reported ☐ On Probation ☐ In Detention
☐ DV Legal Problems ☐ Court Ordered to Treatment

History of Legal Charges
☐ No ☐ Yes
If yes, describe:

Name of Probation/Parole Officer (if applicable)

History of Detentions or Incarcerations
☐ No ☐ Yes
If yes, describe:

Juvenile Court Involvement
Current: ☐ No ☐ Yes Comment:
Past: ☐ No ☐ Yes Comment:

Department of Child Services Involvement with Family
☐ No ☐ Yes
If yes, describe:
Name of CPS Caseworker(s) Assigned to Family (if applicable):

Health Treatment History

History of Inpatient or Outpatient Mental Health Treatment ☐ None Reported ☐ Yes Comment:

Previous or Current Mental or Physical Health Diagnoses (include any pregnancies)
☐ None ☐ Not Known by Client ☐ Yes

Primary Care Physician (name, phone number, address)	**Date of Last Physical Exam**

Other Prescribing Physician(s) (name, phone number, address)

Substance Use History

Illegal drug use/abuse past 12 months?	☐ No	☐ Yes	Non-prescription drug abuse past 12 months?	☐ No	☐ Yes
Prescription drug abuse past 12 months?	☐ No	☐ Yes	Alcohol use/abuse past 12 months?	☐ No	☐ Yes

Check All That Apply
☐ IV Drug User ☐ Other Addictive Behaviors:

Other Comments Regarding Substance Use, Addiction, and Other Addictive Behaviors (include AoD use/abuse by other family members/significant others, AoD related legal problems, SAMI stage of treatment for providers using dual disorders integrated treatment approach):

Trauma & Abuse History

☐ No Trauma or Abuse History	☐ Physical Abuse	☐ Domestic Violence/Abuse	☐ Community Violence
☐ Neglect	☐ Emotional Abuse	☐ Sexual Abuse/Molestation	☐ Natural Disaster

☐ Other:
Comments (describe; identify if client was victim, perpetrator, or both):

Any Other Service Assistance Requests, Recommendations or other Identified Needs

Comments:

PLEASE EMAIL COMPLETED FORM TO: thewrap@connections-inc.net