New Life
Adolescent Services
REFERRAL

Phone: (757) 595-3890 or Fax: (757) 595-3891
www.newlifeco.net

REFERRAL FORM

Client Information

Client Name: _____ Gender M /F
Date of Initial Contact: _____ Date of Birth: _____
Client Race: _____ Social Security #_____
Medicaid #: _____ Provider: _____

Type of Service: □ Intensive In-Home □ Therapeutic Day Treatment/After-School
Are you currently receiving services? Yes/No
If yes, are you satisfied with your current provider? Yes/No
Appointment Date/Time: _____

Parent/Guardian Information

Parent/ Guardian: _____

Current Address: *Phone Numbers*
_____ (H) _____
_____ (C) _____

Serviceable Problems (Circle)

Aggression/Bullying	Involvement w/Courts	**Poor Coping Skills**
Peer Relationship	**Depression**	Parent/Child Relationships
Peer Violence	Abusive Language	Lack of Family Structure
Substance Abuse	Teen Parenting	Juvenile Arrest
Defiance	Gang Violence	**School Failure**/Truancy

Additional Serviceable Problems: _____

Referring Information

Referring Source Relationship:_____ Referring Source #:_____

1. Is the client currently residing in the home? Yes/No
2. Are services able to be delivered in the client's current residents? Yes/No
3. Is one parent or responsible adult with whom the child is living, willing to participate in the therapeutic services, with the goal being keeping the child with the family or transitioning the child home? Yes/No
4. Is the child willing to participate in services? Yes No

Name (person completing referral) _____ Phone: _____
Signature: _____ Date: _____