Confidential

CDS Family & Behavioral Health Services, Inc.

UNIVERSAL YOUTH REFERRAL FORM

www.cdsfl.org

Interface N.W. Youth Shelter
1884 S.W. Grandview Street
Lake City, FL 32025
PHONE: (386) 487-0190
FAX: (386) 487-0195

Family Action Northwest
1884 S.W. Grandview Street
Lake City, FL 32025
PHONE: (386) 487-0190
FAX: (386) 487-0195

REFERRED BY:

Name: _____ **Referral Date:** _____

Title: _____ **Person Completing Form:** _____

Agency: _____ **Phone:** _____

Email: _____ **Fax:** _____

IDENTIFIED PARTICIPANT:

Name of Child: _____ **Date of Birth:** _____

Name(s) of Parents/Legal Guardian/Custodian: _____
name relationship

_____
name relationship

Address: _____
street city zip

Phone #: (H)_____ **(W)** _____ **(C)** _____

School: _____ **Grade**_____ **Social Security:** _____

E.S.E. _____**Yes** _____ **No If yes, what is the disability?**_____

Child aware of the referral? _____**Yes** _____ **No** **Parent aware of the referral?** _____ **Yes** _____ **No**

REFERRED FOR: (check all that apply) ☐ **Truant/ School concerns** ☐ **Runaway** ☐ **Lockout** ☐ **Ungovernable**
☐ **Family concerns** ☐ **Behavior concerns** ☐ **Substance use** ☐ **Other**

Briefly explain the presenting problem: _____

_____

_____

_____

CINS/FINS CRITERIA:

Does referral involve abuse, neglect, or abandonment? _____ **Yes** _____ **No**

If yes, was DCF contacted? _____

Are there pending allegations or referrals for delinquency? _____ **Yes** _____ **No**

If yes, what charge? _____

Is the child under supervision with DCF or DJJ for adjudication for dependency or delinquency? ___**Yes** ___ **No**