



SHIAWASSEE Health & Wellness

YOUTH INTERVENTION REFERRAL FORM

REFERRAL SOURCE INFORMATION:

Referring Source/Agency: _____ Date: _____

Person Making Referral: _____ Phone: _____

YOUTH INFORMATION:

Youth Name: _____

Address: _____

School and Grade: _____

Phone #: _____ DOB: _____

Race/Ethnicity: _____

Parent/Guardian Name: _____

Parent/Guardian eMail: _____

Insurance Name and Policy: _____

PARENT/GUARDIAN CONSENT – MUST be signed prior to referral being submitted

I have been given the Youth Intervention Program description and have requested to participate in the program.

I understand that I may be referred to other resources in the community for services.

I authorize Shiawassee Health and Wellness, Youth Intervention Specialist, to perform screening to identify signs of mental/emotional disturbance, distress, substance abuse issues and patterns of problem behavior.

I understand this authorization will expire on _____ (*not to exceed one year*) or upon termination of services.

I authorize the Youth Intervention Specialist to have verbal communication and/or send a follow-up letter regarding my child with (referral source):

(Print Referral Source Name)

Parent/Guardian Signature

Date

Parent/Guardian Printed name