



ACT TOGETHER CRISIS CARE REFERRAL FORM

Staff Processing Referral _____ Date of Referral: _____

Youth's Full Name: _____ Age: _____ Sex: _____ DOB: _____

Address: _____
S TREET ADDRESS CITY STATE ZIP CODE COUNTY

Referral Source: _____ Agency/Phone: _____ / _____

Youth's Legal Guardian: _____ Phone _____

Guardian's Full Address: _____
(If different from youth's)

Youth's Present Living Situation: _____

Crisis Situation / Reason for Referral: _____

Problems (Check those that apply & include details with frequency & duration):

_____ Court Involvement Charges: _____

Probation: Y N Terms of Probation: _____

_____ Attending School (School Name & Grade): _____

_____ Suspension _____ Expulsion _____ Other: _____

_____ Suicidality (Description): _____

_____ Homicidality (Description): _____

_____ Verbal Aggression: _____ Physical Aggression: _____

_____ Gang Involvement: _____

_____ Substance Abuse: _____ Runaway: _____

_____ Fire Setting: _____

_____ Sexual Acting Out: _____

_____ Established Mental Health Diagnosis: _____

Physical Medical Conditions: _____

Hospitalization(s) (Date, Place, Reason): _____

Mental Health Treatment: _____

Medications (List): _____

Has the youth been admitted to AT previously? Y N If yes, when? _____

Out of Home Placement Pending: _____

Additional Information: _____

Staff Use Only :

DISPOSITION: _____

ADMISSION	INACTIVE	DENIAL
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Staff Notes :
