



Youth and Family TREE REFERRAL FORM

Today's Date: \_\_\_\_\_

Referral Source/Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

- Is the client age 12-25?
Has Youth and Family TREE services been discussed with the client?
Is the client willing to participate?

Client's Name: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Guardian Name(s): (mother) (father)

Preferred Phone: ( ) OK to leave message? Yes No
Alternate Phone: ( ) OK to leave message? Yes No

Best time of day to contact and/or schedule sessions \_\_\_\_\_

Permanent Address: Street City State Zip

Reason for referral: Only one option is required for a referral but please select all that apply

- Tobacco Marijuana Prescription Medications Other:
Vape Methamphetamine Cocaine Other:
Heroin Fentanyl Alcohol Other: