



# PROFESSIONAL REFERRAL FORM

Send referral form to [jfunkhouser@arapahoegov.com](mailto:jfunkhouser@arapahoegov.com) or call Connections for Families/RISE at (303) 646.8119 to schedule an appointment

REFERRAL DATE:

YOUTH'S SCHOOL:

GRADE:

YOUTH'S NAME:

DOB:

GENDER: M  F

PLEASE CHECK ANY OF THE FOLLOWING ISSUES THAT APPLY:

- PEER CONFLICTS
- ATTENDANCE
- ACADEMIC PERFORMANCE
- SUSPENSIONS
- EXPULSION(S)
- BEHAVIORAL REFERRALS
- MENTAL HEALTH
- FAMILY
- SUICIDAL
- HOMICIDAL
- VIOLENCE/AGGRESSION
- SUBSTANCE USE
- BCOP (BEYOND CONTROL OF PARENT)
- RUNNING AWAY
- GANG INVOLVEMENT
- OTHER:

PARENT/GUARDIAN NAME:

RELATION TO YOUTH:

Address:

Phone:  cell or  home

email:

WHAT LANGUAGE DOES YOUTH SPEAK?

WHAT LANGUAGE DOES PARENT/GUARDIAN SPEAK?

DOES STUDENT HAVE AN IEP OR 504 PLAN? **\*\*PLEASE SPECIFY\*\***  Y  N

DOES (S)HE RECEIVE SUPPORT SERVICES OR A PART OF THE MTSS PROCESS?  Y  N: specify

STUDENT INVOLVED IN SARB/CARB OR TRUANCY COURT?  Y  N: specify

DID REFERRAL PARTY DISCUSS REFERRAL FOR ASSESSMENT WITH PARENT/GUARDIAN?  Y  N: specify

PARENTS GIVE PERMISSION TO HAVE JAC STAFF INITIATE CONTACT?  Y  N: specify

IS THE DEPARTMENT OF HUMAN SERVICES INVOLVED?  Y  N: specify

**ADDITIONAL COMMENTS:**

**PARENTS/GUARDIANS CAN ALSO CALL US AT 303-646-8119 TO SCHEDULE AN APPOINTMENT**

REFERRING PROFESSIONAL:

TITLE:

REFERRING ENTITY:

PHONE:

CONTACT EMAIL:



In collaboration with Juvenile Assessment Center