# The TEEN INTERVENE Program

## INITIAL REFERRAL FORM

Name: _____ Referral Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ D.O.B._____/_____/_____

Parent/Guardian: _____

Home #: _____ Work#: _____ Cell #: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: Specify _____

Race: ☐ Caucasian ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic
☐ Native American ☐ Other: _____

Referral Source: _____ Referral Phone Number: _____

Reason for Referral/Presenting Problem: _____

_____

_____

_____

_____

Check One: New Case: Yes ☐ No ☐

Circle one: Virtual/ In- Person

Program Supervisor: _____Staff Signature: _____