

YOUTH ENHANCEMENT PROGRAM

Bitterroot Valley Education Cooperative
PO Box 187
Stevensville, MT 59870

CONFIDENTIAL REFERRAL FORM

Referral Source: _____ Date: _____

Principal's Signature (if school referral): _____

Child's Name: _____ DOB: _____

Social Security Number: _____ Grade: _____

School: _____

School Contact Person: _____

Is this child in Special Ed? (IEP or 504): _____

Current Residence/Placement: _____

Address: _____

_____ Phone1: _____

Best Time to Contact: _____ Alt. Phone: _____

If current residence is not with the Custodial Parent or Guardian, who has guardianship?

Address: _____

_____ Phone1: _____

Best Time to Contact: _____ Alt. Phone: _____

Reason for Referral: _____

(More on other side)

Observed Behaviors/Presenting Problems:

(Please be specific; What, When, Where, With Whom?)

Is this child on medication(s)? _____ Which one(s)? _____

Services/agencies currently involved with child or family:

Psychologist/Therapist: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Youth Court, contact: _____ Phone: _____

CFS, contact: _____ Phone: _____

Crossroads/Chemical Dependency, contact: _____ Phone: _____

Foster Care, which agency? _____

Contact: _____ Phone: _____

Other: _____

List which adults in the child's life have been contacted about this program, and whether he or she is interested in the child receiving services.

Who made the contact? _____

Number in child's household: _____ Household income: _____

Any Insurance? (Medicaid, Chip, or private pay) _____

Please return this form to a YEP staff member:
BVEC PO Box 187, Stevensville, MT 59870
