POSITIVE ADVERSITY YOUTH SERVICES INC.
THERAPEUTIC MENTORING
REFERRAL FORM

Please download and print this form. Complete it and email it to Positive Adversity Youth Services using the contact information listed at the bottom of the form.

Date of Referral: ______________________________ Child Car Safety Seat Needed? Yes No

Child/Youth Name: ____

Date of Birth: _________________________________ The child/youth is: Male Female

Full Address: ____
Street City/Town State Zip

Family Information:

Parent / Caregiver's Name: _____________________________ Relationship to child/youth: ______________

Home Phone: ______________________________ Cell Phone: ____________________________

Primary language of child/family: ____

Primary Care Physician: ____

Is family / guardian aware and in agreement with referral? Yes No

Has family been informed about what the service offers? Yes No

Mental Health Diagnosis:

Primary: _______________________________________ DSM V/ICD10 Code: _______________

Secondary: ____________________________________ DSM V/ICD10 Code: _______________

Goal(s):

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**Therapeutic Mentoring interventions are designed to address one or more goals on a youth's existing outpatient or In-home therapy treatment plan.*

Reason for Referral:

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Is the youth involved with Department of Children & Families (DCF) or Department of Social Services (DSS) or Court Support Service Division (CSSD) or Department of Developmental Services (DDS)? Yes No

If yes, please list the name and contact information for the DCF/DSS/CSSD/DDS caseworker(s) and briefly describe the reason for involvement:

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Is the youth currently being treated for an active medical diagnosis? Yes No
If yes, please explain:

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Please include with this referral:

______ Copy of release of information from referral source
______ Copy of Care Plan or Treatment Plan

Referred by: (check one)
____ Case Worker ____ In-Home Therapist ____ Outpatient Therapist ____ Other

Agency: ____

Name of person referring: ____

Phone: ___________________________ Email: _____________________________________

Number of Hours Approved ______

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Therapeutic Mentoring Program
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