Lakeview Health Services
Achieving goals. Advancing lives.

YOUTH OUTREACH REFERRAL FORM

Lakeview Health Services, Inc.

Referral Source

Date	Referred By	Agency	Phone Number

Client Information

Name: ☐ Male ☐ Female
Date of Birth: SS#:
Address: Phone:

Primary Caregiver(s)

Name: Relationship:
Contact Number (if different than above):
Has parent or caregiver been informed of referral? ☐ *Yes* ☐ *No*

School Information (if known)

Current School: District:
Grade Level: Educational Format: ☐ Mainstream ☐ 504 / IST ☐ Blended
IEP ☐ Yes ☐ No ☐ Self-contained ☐ Life skills ☐ Experiential

Presenting Concerns:

Current Service Providers and Supports (if known)

Presenting Concern(s)	**Potential Service Objective(s)**
☐ Criminal activity ☐ Delinquency ☐ Depression/mood disorder ☐ Eating disorder ☐ Family relational problems ☐ Fighting/aggression: to family ☐ Fighting/aggression: to peers ☐ Financial hardship ☐ Fire setting ☐ Learning Disability (classified) ☐ MRDD (classified) ☐ Medical/physical handicap ☐ Neighborhood problems ☐ Parental/caregiver neglect ☐ Parent-Child relational problems ☐ Peer-to-peer relational problems ☐ Physical abuse/assault victim ☐ Physical abuse perpetrator ☐ Police involvement ☐ Pregnancy ☐ Runaway/elopement ☐ School difficulties ☐ Self-abuse ☐ Sexual abuse/assault victim ☐ Sexual activity/promiscuity ☐ Sexual perpetration ☐ Social/interpersonal relational problems ☐ Substance abuse/use ☐ Suicidal attempt (in past year) ☐ Suicidal ideation ☐ Teen/underage parent ☐ Thought disorder ☐ Truancy ☐ Violence to others ☐ Other (specify on front of form)	☐ Academic/school support ☐ *Big Brother/Big Sister** ☐ Case management ☐ *DDSO/ARC services** ☐ Educational advocacy ☐ Employment assistance ☐ Financial management ☐ *Finger Lakes Parent Network** ☐ *Functional Family Therapy** ☐ GED assistance ☐ Home crisis support ☐ Job Coaching ☐ *Multi-Systemic Therapy** ☐ *Outpatient Therapy Provider** ☐ Parent education/training ☐ Parenting support ☐ *PINS/Probation** ☐ *Preventive Services/DSS** ☐ Safety Planning ☐ *Skillbuilding** ☐ Transportation assistance ** Additional Support Services that may be linked to client.* **FOR OFFICE USE ONLY** *Date Received* | *Received By* *Contact Notes*

Additional Comments

Please Send Referral To:
Lakeview Health Services, Inc.
Ontario County CSS/Youth Outreach
611 West Washington Street
Geneva, NY 14456

Or Fax to:
315-789-0555
Attn: Ontario County CSS/Youth Outreach