Shiloh House
Community - it's what we are, it's where we are.

Community Based Programs Referral Form

Date of Referral: _____ **Referring Party Name**: _____ **Agency Affiliation**: _____

Phone Number: _____ **Email Address**: _____

Client Name: _____ DOB: _____ **Ethnicity: _____ Race: _____**

Biological Gender: Male_____ Female_____ **Medicaid #: _____ Is there an open DHS case?** Yes_____ No _____

County: _____ **Custody**: _____ **Currently Living**: _____

Legal Guardian and contact information (address, phone and email):

_____

Parent 1 and contact information (DOB, address, phone and email):

_____

Parent 2 and contact information (DOB, address, phone and email):

_____

Sibling names and information (DOB and gender):

_____

Caseworker and contact information (name, phone and email):

_____

PO and contact information (name, phone and email):

_____

Pre-Trial Officer and contact information (name, phone and email):

_____

GAL and contact information (name, phone and email):

_____

Outside Therapist and contact information (name, phone and email):

_____

Services Requested:

Please define which services you are requesting by writing "yes" or "no" in the spaces provided below:

Life Skills Coaching:	**Life Skills/Therapy Combined:**	**Social Skills:**
Beyond The Walls:	**Supervised Visitation:**	**Rapid Response:**
Parenting Support:	**Safety Planning:**	**Classes:**
Evening Reporting Center:	**Mentoring:**	**Parents as Teachers (PAT):**
Outpatient Individual/Family Therapy (Office):	**Outpatient Individual/Family Therapy (Home):**	**Offense Specific/Problematic Sexual Conduct (PSC) Services:**
Other:	**Other:**	**Other:**

Reason for Seeking Services (presenting problem, duration, readiness for treatment, chief complaint):

Mental Health History for Youth (social relationships, spiritual beliefs, risk factors, cultural factors, communication needs and coping skills):

Family Relationships and History (family constellation, dynamics, separations, divorces, deaths, familial substance use, and familial mental health issues):

Community Relationships (extracurricular and/or pro-social activities, supportive non-family individuals, mentors):

Trauma History (history of exploitation, human trafficking, family violence, abuse and neglect, current risk level):

Safety Concerns for Providers in the Home (aggressive clients, weapons in the home, aggressive animals):

Cognitive Functioning of Youth and Family (any cognitive delays, developmental delays, capacity for self-sufficiency):

History of Gang Involvement? Yes_____ No _____ Unknown _____ Suspected _____

History of Human Trafficking? Yes_____ No _____ Unknown _____ Suspected _____

Goals for Services:

Please select areas that youth & family would like to work on (please select at least 3):

Anger Management:	**Education/Schoolwork:**	**Pro-Social Activities:**
Time Management:	**Employment:**	**Social Skills:**
Truancy:	**Delinquent Behavior:**	**Community Service:**
Parenting Support:	**Safety Planning:**	**Other:**
Other:	**Other:**	**Other:**

Client and Family Strength's (skills, abilities and interests):

Client: _____

Family: _____

What is currently going well in the home?

_____

History of Services (please list **ALL** previous community resources and services):

Type of Service	Name of Service	Dates of Service Referral	Outcome of Service

Education

Is the youth on an IEP? Yes_____ No _____ Unknown _____ Would like youth to be assessed _____

Home School District: _____

Currently passing classes: Yes_____ No _____

Currently involved in truancy court: Yes_____ No _____

Legal History for Youth

Charges: _____

Adjudications: _____

The following section should be completed by Shiloh House staff only:

Date referral was received: _____

Outreach Attempts (please enter date & time of all outreach attempts to family)**:**

1. _____
2. _____
3. _____

Family's availability: _____

Intake Scheduled for (enter date & time)**: _____**

Staff Assigned: _____

Program(s) Assigned:

1. _____
2. _____
3. _____

Paying Agent: _____

Additional Information: