

Child/Youth's Name: _____

Address: _____

Child/Youth's Date of Birth: _____ Child/Youth's Preferred Pronouns: _____

Guardian's Name(s): _____

Best person to contact and relationship: _____

Best way to contact (call, text, email): _____ Okay to leave voicemail message? Yes No

Phone number and/or E-mail address: _____

Reason for Referral:

Overview of Concerns

What support do you hope we can provide?

- CONTINUED ON NEXT PAGE -

Anything else we should know to improve access?

What supports is your organization (and others) providing?

Referral created by:

Name: _____

Position: _____

Organization: _____

Contact Information: _____

Check to confirm process has been followed:

- Consent attached (signed by parent/guardian(s) and youth older than 12 years old)
 - made out to Lutherwood/Carizon Mental Health Services
- Referred youth/family is aware that Front Door is being contacted

Date Created: _____