



I CARE serves youth up to age 21 who are at-risk **OR** have experienced CSE. Please mark below the services the youth and/or family are interested in.

Before making a referral, please be sure youth are aware that a referral is being made and that they are informed of the population we serve. I CARE services are voluntary.



Client/Guardian has been notified of referral? Date: _____

<i>Potential Clients Info</i>	Legal Last Name	Legal First	Legal Middle	Gender Pronoun	Preferred Language
	Address		Phone Number(s)		Ok to leave VM?
	Social Security #	Date of Birth	Ethnicity	Email Address	
	Please select applicable coverage potential client has: <input type="checkbox"/> No Coverage <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Other Coverage Policy ID: _____ Name of Insurance: _____				
<i>Parent / Legal Guardian Info</i>	Legal Last Name	Legal First	Preferred Language	Email Address	
	Address <input type="checkbox"/> Same as potential client		Relationship to Client	Phone Number(s)	
<i>Referral Info and Consents</i>	Screening Questions: 1. Has anyone ever given the youth anything for sex (i.e. money, place to stay or food)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 2. Does the youth have someone who gets them in contact with people to have sex (i.e. pimp, trafficker, "boyfriend" or "girlfriend")? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 3. Check all that apply or have applied: <input type="checkbox"/> Truancy <input type="checkbox"/> Homelessness <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Foster Care <input type="checkbox"/> Runaway/AWOL <input type="checkbox"/> Self or family member experienced sexual assault 4. <input type="checkbox"/> Self or family member experienced domestic violence <input type="checkbox"/> Sends or posts provocative photos of self 4. Does the youth have relatives or friends who have been known to exchange sex for anything (i.e. money, place to stay or food)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 5. CSE-IT Score (Probation & CWS, if completed, please attach CSE-IT Screening): _____ 6. Who is the youth currently living with (If in custody provide release date): _____				
	Reason for referral / additional information (Client's need, how does client feel about services, what would client like to work on, any other relevant history):				
	Any safety concerns for providers doing home visits (animals, weapons, etc.)?				
	<input type="checkbox"/> Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option or Youth has had at least one emergency psychiatric hospitalization in the past 24 months. Date of hospitalization: _____ <input type="checkbox"/> Early signs of psychosis If yes, please specify: _____				
	Substance use: <input type="checkbox"/> Current <input type="checkbox"/> Historical <input type="checkbox"/> Unknown If current or historical substance use, please list substances:				
	Please check all appropriate areas of need/concern: <input type="checkbox"/> auditory/visual hallucinations <input type="checkbox"/> depressed/sad <input type="checkbox"/> probation/legal issues <input type="checkbox"/> death of a family member <input type="checkbox"/> divorce/separation <input type="checkbox"/> angry/argumentative <input type="checkbox"/> irritable <input type="checkbox"/> anxious <input type="checkbox"/> threat to others <input type="checkbox"/> threat to self <input type="checkbox"/> self-injury <input type="checkbox"/> gang affiliated <input type="checkbox"/> health issues <input type="checkbox"/> learning disability <input type="checkbox"/> inattentive <input type="checkbox"/> disruptive <input type="checkbox"/> declining grades <input type="checkbox"/> low self-esteem <input type="checkbox"/> withdrawn/isolates <input type="checkbox"/> social problems				
	Potential client interested in receiving services? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Parent / legal guardian interested in participating in services? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Services Youth is interested in (please check all that apply): <input type="checkbox"/> Case Management <input type="checkbox"/> Housing <input type="checkbox"/> Education <input type="checkbox"/> Employment <input type="checkbox"/> Peer Support/Support Groups <input type="checkbox"/> Psychiatry <input type="checkbox"/> Therapy <input type="checkbox"/> Caregiver Support				
	Referring person's Name / Organization / Phone / Email:				
Date of Referral:					

Office Use Only

SP #: _____

Date Attempted: _____ Outcome: _____

Date Attempted: _____ Outcome: _____

Date Attempted: _____ Outcome: _____

Date Attempted: _____ Outcome: _____

Reason Youth/Family Didn't follow through: _____

Intake Appointment Date/Time/Location: _____

Program: CRT OVC NCLL ICARE

Assigned Staff: _____

Referral Source Updated On: _____

Outcome (referral information that was updated with youth or referral source: _____

