Referral Form for STARS/I CARE
Phone: (619) 521-2250 · Fax: (619) 521-5944 · sdyouthservices.org

STARS serves those who have experienced CSE/HT between the ages of 12-24. I CARE serves youth up to age 21 who are at-risk **OR** have experienced CSE. This one referral form covers both programs. Please mark below the services the youth is in need of and services will be assigned based on those needs.

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. STARS & I CARE services are voluntary.

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

Potential Clients Info	Legal Last Name	Legal First	Legal Middle	Gender Pronoun	Preferred Language
	Address		Phone Number(s)		Ok to leave VM?
	Social Security #	Date of Birth and Age	Ethnicity	Email Address	
	Please select applicable coverage potential client has: ☐No Coverage ☐Medi-Cal ☐Other Coverage Policy ID:_____ Name of Insurance:_____				
	Who is the youth currently living with (If in custody provide release date)				
Parent / Legal Guardian Info	Legal Last Name	Legal First	Preferred Language	Email Address	
	Address ☐ Same as potential client		Relationship to Client	Phone Number(s)	

Referral Info and Consents

Screening Questions:

1. Has anyone ever given the youth anything for sex (i.e. money, place to stay or food)? ☐ Yes ☐ No ☐ Unknown
2. Does the youth have someone who gets them in contact with people to have sex (i.e. pimp, trafficker, "boyfriend" or "girlfriend")? ☐ Yes ☐ No ☐ Unknown
3. Check all that apply or have applied: ☐ Truancy ☐ Homelessness ☐ Substance Abuse ☐ Foster Care ☐ Runaway/AWOL ☐ Sexual Assault (self or familial) ☐ Domestic Violence (self or familial) ☐ 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)? ☐ Yes ☐ No ☐ Unknown
5. CSE-IT Score (Probation & CWS, if completed, please attach CSE-IT Screening): _____

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.)?

Please check appropriate behavioral symptoms
☐angry ☐argumentative ☐depressed ☐irritable ☐sad ☐anxious ☐threat to others ☐threat to self ☐ self-injury
☐learning disability ☐inattentive ☐disruptive ☐declining grades ☐low self-esteem ☐divorce/separation
☐social problems ☐withdrawn/isolates ☐health issues ☐gang affiliated ☐death of a family member ☐probation/legal issues

Potential client interested in receiving services? ☐ Yes ☐ No
Parent / legal guardian interested in participating in services? ☐ Yes ☐ No

Services Youth is interested in (please check all that apply):
☐ Case Management ☐ Housing ☐ Education
☐ Employment ☐ Peer Support/Support Groups ☐ Psychiatry
☐ Therapy ☐ Caregiver Support ☐ CSEC Response Team (Referrals only open to CWS: 5-10 day referral)

Referring person's Name / Organization / Phone / Email:

Date of Referral:

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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: _____
_____

SAN DIEGO YOUTH SERVICES
LIVE WELL SAN DIEGO
COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY