

Referral Form for Youth and Family Recovery Program

Youth Name _____ D.O.B. _____

Caregiver's name _____ Relationship to youth _____

Caregiver's Phone _____ Best time to Contact _____

Address _____

1. What is the reason for the referral?

2. Are there any significant issues in the family?

3. Does the Caregiver know about this referral? Yes ___ No ___

4. Are they willing to participate in treatment? Yes ___ No ___

5. Has a Release to share information been signed? Yes ___ No ___

Referral Agency _____

Contact Person _____ Date _____

Phone _____ Cell _____ Fax _____

How did you find out about us? _____

Please Return Forms to:

Youth and Family Recovery Program
Phone 352-516-7983 Fax 352-360-6628
Email: twright@lsbc.net
P.O. Box 491000, Leesburg, FL 34749