Second Chances Youth Services, LLC *20 East Tabb Street, Suite # 100* *Petersburg, VA 23803*	12 VAC 35-105-640

Referral and Prescreening

Date of Referral: _____

Identifying Information

Method of Screening:
❒ Telephone ❒ Written ❒Face to Face

Name_____ DOB: _____ Race _____

Gender: □ female □ male SSN# _____ Medicaid # _____

Address: _____ Telephone: _____

Parent/Authorized Representative Name: _____ Telephone: _____

Address: _____

Referral Source Name: _____ Referral Source Agency: _____

Referral Telephone: _____ Referral Fax: _____

Referral Address: _____

Current Problems: (Circle as many as applicable)

Anger management

Sibling Rivalry

Defiance towards authority figures

School Conflict

Difficulty sitting still

Unable to focus

Difficulty maintaining peer friendships

Fighting

Verbal Aggression

Running Away from Home

Truancy

Teen Pregnancy

Juvenile Justice/Court Involvement

Other _____

Psychiatric History:

Medical History: (include current medications)

Communication Barriers:

Screening recommendation and disposition plan:

☐ Based on the above information and information obtained, applicant is appropriate for the program and will be admitted.

- ○ If applicant is appropriate for services, the assessment is scheduled for: Date: _____ Time: _____

☐ Based on the above information and information obtained, applicant is **not appropriate** for services and will be recommended for appropriate services. Recommendations are: _____

Counselor signature; _____ Date _____