710 Mount Vernon Avenue, Suite 1

Huntingdon, PA 16652

Office #: 814-506-8651

Send referrals to contact@evolutionhuntingdon.com



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| **DATE OF REFERRAL**  | **REFERRAL SOURCE** | **REFERRAL CONTACT #** |
|  |  |  |
| **CYF/JPO ASSIGNED STAFF** | **PREFERRED COMMUNICATION** | **PREFERRED CONTACT INFO** |
|  | CELL / OFFICE PHONE / EMAIL |  |
|  |
| **CYF/JPO ASSIGNED SUPERVISOR** | **PREFERRED COMMUNICATION** | **PREFERRED CONTACT INFO** |
|  | CELL / OFFICE PHONE / EMAIL |  |

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| **PRIMARY ADOLESCENT** |
| **FULL NAME** | **DOB/ AGE** | **Male/Female/Other** |
|  |  |  |
| **STREET ADDRESS** | **CITY, STATE and ZIP CODE** |
|  |  |
| **EMAIL ADDRESS** | **HOME PHONE** | **CELL PHONE** |
|  |  |  |
| Who has legal custody of the adolescent? |  |
| Where does the adolescent currently reside? |  |
| Does family have reliable transportation? |  |

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| **REASON FOR REFERRAL** |
|  |
| **Group being referred:** [ ]  **ALLIES** [ ]  **Arts for Healing**  |
| **SERVICES CURRENTLY INVOLVED IN FAMILY** |
|  |
| **SCHOOL INFORMATION** |
| School attending: Current grade:  |
| **FAMILY & HOUSEHOLD** |
| **Mother / Female Guardian Name** | **Relationship** | **Contact Info** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  |
| **Father / Male Guardian Name** | **Relationship** | **Contact Info** |
|  |  |  |
| History of substance abuse, violence, or mental health involvement? |  |
| **Number of siblings living in home** | **Other key supports** |
|  |  |

Any additional info:

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