



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Reach & Rise® Youth Referral Form

Please send referral form to:

Kevin Sisson, MA
Ocean Community YMCA
95 High Street Westerly, RI 02891
(401)-596-2894 ext.121 / Fax: (401)-596-4031 / ksisson@oceancommunityymca.org

Child Information:

Child's Name: Gender: M F Age: DOB:

Address: City: Zip Code:

Parent/Guardian Name(s): Relationship to Child:

Address (if different from child): Home #: Work #:

Cell #: Email:

Child's School: School City: Grade:

Ethnicity (Optional): African American Caucasian Latino

Asian Pacific Islander American American/Alaska Native Unknown Multi-Racial

Other:

Language Spoken by Child: English Only Other (specify): Both languages

Referral Information:

Name of Person Making Referral: Referral Date:

Agency/Program/Relationship to Child:

Phone #(s): Email:

Best Way to be Contacted: Home # Cell # Work # Text Email In Person

Best Times to be Contacted:

Family Information:

Child Lives With: Married Parents Unmarried Parents Single Parent
 Divorced Parents/Shared Physical Custody Step-Parent/Blended Family Foster Family
 Family Member Other

Custody (if parents are divorced) who has 100% legal custody: Mother Father Joint (50%)



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People Child Primarily Lives With:

Name	Relationship to Child	Age	Work / Cell Phone

Significant Others Not Living in Household:

Name	Relationship to Child	Age	Work / Cell Phone

Language Spoken By Parent: English Only Other (specify) Both languages

Are you a part of a Military Family? YES NO Branch Type:

Has a Child Protective Referral ever been made? YES NO

If yes, please describe:

REFERRAL INFORMATION:

Reason(s) for Referral: (check all that apply)

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Positive Role Model | <input type="checkbox"/> Family Conflict | <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> Grief/Loss |
| <input type="checkbox"/> Try New Activities | <input type="checkbox"/> Emotional Support | <input type="checkbox"/> Gang Related | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Friendship Building | <input type="checkbox"/> History of Abuse | <input type="checkbox"/> Impulse Control | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> School Behavior | <input type="checkbox"/> Runaway | <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Missing School | <input type="checkbox"/> Homeless | <input type="checkbox"/> Body Image | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Peer Conflict | <input type="checkbox"/> Arrests/Legal Issues | <input type="checkbox"/> Eating Issues | <input type="checkbox"/> Other: |

Describe the reason(s) for the referral to the mentoring program. Any recent changes with the child noticed? Any recent changes with child's family or living situation? Any specific challenges or difficulties? If so, what and when did they begin?



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What are some goals you think would be good for the child? What could improve the child's life?

What would the child say is the reason she/he is being referred? What would she/he see as a goal?

Is she/he on waiting list or enrolled in any other mentoring programs? Yes or No

Any mentor preferences? Male/female mentor (male mentors are only matched with male youth)?
Specific ethnicity or cultural background?

What are the days and/or times child is available to meet weekly with a mentor?

Has this referral been discussed with the child & parent/guardian? (If made by someone other than parent/guardian)? If yes, when? What was their response/are they interested in having a mentor for their child?

What are the child's strengths? What is she/he good at?

What are the child's hobbies/interests?

School Information: What do the teachers say about the child? How are his/her Grades? Are there behavior problems? Any previous SST Meetings? If yes, when? Does child have an IEP or 504 Plan? Ever been referred for special education.



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Peer Relationships: How does child relate to peers? Any significant relationships? Any difficulties getting along well with peers? Any specific age groups child relates best with?

Has family &/or child ever attended counseling? If yes, where? When? For what reasons?

Family History: Any changes/stressors for child/family (moves, deaths, births, remarriage, separations/divorces, witness any accidents, trauma, domestic violence, etc.)? Who does child primarily live with? Any specific custody/visitation arrangements if parents are divorced/separated? Who is most actively involved with the child? What are relationships between family members like?

Are there any specific cultural issues for child/family that would be helpful to know?

Any serious past or present medical conditions, illnesses, injuries, surgeries, hospitalizations, ongoing treatment, etc. for child or family?

Any history of substance use/abuse in family or with child? If yes, what kind? With what frequency?

Any history of child or family members with suicidal thinking or suicide attempts? If yes, when?

