SUPPORT
INCORPORATED

Therapeutic Level II Referral Form

When completed, return via fax to 704-865-3010

Referral Date: _____

Contact Person & Number: _____

Referring Agency: _____

CLIENT INFORMATION

Name: _____ Sex: _____

Race: _____ Age: _____ Religious Preference: _____

In legal custody of: _____

Currently living: _____

Diagnosis: _____

Presenting Problems:

_____

_____

_____

Client strengths:

_____

_____

_____

School Information (Name of school, grade, any behavior concerns):

_____

_____

Risk factors (Sexual/Physical abuse, Suicidal, Hospitalizations, Running away, Drug use):

_____

_____

Professional Involvement (DJJ, therapist, psychiatrist):

_____

_____

Specific requests for family/location:

_____

For Level II Use: Follow Up: _____

_____

_____