

Junior Partner Referral

Community Based School Based



This form is to be completed by the referral source and returned to Partners. Information on this form will be kept confidential and will be used to assist the Case Manager in matching the child with an appropriate Senior Partner. Please take the time to fill in all the information completely and return to the Partners Office at 101 N 8th Street, Gunnison, CO Fax 970-642-4259 Phone 970-641-5513

Referring Agency Information

Date: _____
Referring Agency: _____
Person making Referral: _____
Title: _____
Phone: _____

For Office Use Only

Dates Contacted: _____
Comments: _____
Date Interviewed: _____ Case Manager: _____

Has parent/guardian been informed of this referral? Yes No

Child and Family Identifying Data:

Name: _____ DOB: _____
Address: _____ Age: _____ Gender: _____
Ethnic Origin: _____ Language spoken in the home: _____
Child living with: _____

Mother/Stepmother/Guardian: _____ Home Phone: _____
Address (If different from above): _____
Employer: _____ Work phone _____

Father/Stepfather/Guardian: _____ Home Phone _____
Address: (If different from above): _____
Employer: _____ Work phone _____

Brothers/Sisters/ Others in Home: _____ Age: _____ Age: _____
Age: _____ Age: _____

School Data:

Grade: _____ Working at Grade level: _____ Teacher: _____ In Sp. Ed. Program Yes _____ No _____
Child needs assistance in the following academic or other school performance areas:

Best time for a Mentor to work with the child: (Study Hall, Core Support, After school) _____

Child's Interest/Hobbies: _____

Recommendations for matching: _____

Family History

Physical Abuse: _____

Sexual Abuse: _____

Neglect: _____

Drug or Alcohol Dependency: _____

Suicidal Tendencies: _____

Disability: _____

Teen Pregnancy: _____

Mental Health Issues: _____

Violence in the home: _____

Constant Relocation: _____

Familial Difficulty with the Law: _____

Low Economic Status: _____

Behavior

Child acts out at home or in school: Yes ___ No ___ Child has run away? Yes ___ No ___

Child has counseling needs: _____

Displays the following Behavior Patterns:

___ Overly dependent on peers/parent figures ___ Quiet ___ Withdrawn ___ Temper tantrums

___ Experimentation with drugs/alcohol ___ Passive ___ Aggressive ___ Depressed

___ Delinquent behavior ___ Acting out ___ Destructive

School related Behavior Patterns:

___ Low motivation ___ Poor Participation ___ Low Grades

___ Learning Disability ___ Poor attendance ___ Defiant of authority/questions rules

___ Poor peer relations ___ Fighting ___ Disrupts classroom environment

Comments: _____

What school related and other activities does the child participate in?

Legal

Probation: Yes ___ No ___ Prob. Officer: _____ Phone: _____

Diversion: Yes ___ No ___ Div. Counselor: _____ Phone: _____

Please list other contacts with police and juvenile system: _____

Other Agencies working with Child/Family

Agency

Dates of Service

Contact Person

Phone

Additional Comments: _____