



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Reach & Rise® Group Mentoring Youth Referral Form

Please send referral form to:
Shauntay Guions
YMCA of Newark and Vicinity
600 Broad Street Newark, NJ 07102
973.624.8900 Ex:6873
sguions@newarkymca.org

REFERRAL DATE: _____

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%)

Incarcerated Family Member _____

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 Type: _____

Has a Child Protective Referral ever been made? YES NO (if yes, add details below)

REFERRAL INFORMATION:

Reason(s) for Referral: (check all that apply and provide example(s))

- | | |
|---|--|
| <input type="checkbox"/> Social Skills _____ | <input type="checkbox"/> Emotional Support _____ |
| <input type="checkbox"/> School Behavior/Engagement _____ | <input type="checkbox"/> Mental Health _____ |
| <input type="checkbox"/> Family Relations _____ | <input type="checkbox"/> Violence/Trauma _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Describe the reason(s) for the referral to the group 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?

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

Describe the child: (shy, outgoing, disruptive,..)

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?

Would the child benefit from a mix gender group with mix gender mentor facilitators or from a group with same gender group and same gender mentor facilitators?

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

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 the child participate in group mentoring?

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 current 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? Self-harm? If yes, when?

Any arrests, convictions, encounters for the child or family members with the law? If yes, when & what happened? Any Probation Officers worked with the child? If yes, when? Is this ongoing?

Any Child Protective Services &/or Police involvement with the child and/or family regarding child's safety (e.g. physical, verbal/emotional, sexual, neglect, etc.)? If so, when? For what?

THIS SECTION IS FOR PROGRAM STAFF ONLY			
CONTACT LOG			
Log all contact regarding referral (e.g. discussing referral, explaining wait time, scheduling meetings, etc.)			
Date	Y Staff	Person Contacted	Notes – Messages left, contact made, etc.

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