



Together We Own It
255 Clifton Blvd Ste. 308
Westminster, MD 21157
Fax: 443.320.9870

Date of Referral:	
Referring Agency:	Name of Referring Professional:
Reason for referral:	
Referral Phone:	Referral Email:
Youth Name:	
DOB:	
School:	
Last Grade Completed:	
(circle one): MALE/FEMALE	Race/Ethnicity:
Allergies/Medical Conditions/Mental Health Diagnosis:	
Medications Prescribed (if any):	
Legal Guardian:	Relationship:
Physical Address:	
Mailing Address:	
Guardian Phone:	Guardian Email:
Is participation in this program court ordered?	
Is participation in this program a part of a diversion plan/contract? (If yes, please explain. i.e contingency, consequences, etc.):	

Problem Behaviors/Risk Indicators (Individual, School, Community, Peer):

- ☐ Bullying Behavior
- ☐ Negative Labeling/Bullied
- ☐ Crime/Delinquency
- ☐ Fighting/Assault/Aggressive Behavior
- ☐ Fire Settings
- ☐ Impulsive/Risk
- ☐ Mental Health Issues
- ☐ Lack of Social Skills
- ☐ Sexual Offense
- ☐ Sexual/Substance/Physical/Mental Abuse/Victimization/Trauma
- ☐ Suicide Attempts
- ☐ Suicidal Ideations/Threats

- Gang Affiliation/Involvement/Association
- Negative Peer Associations/Aggressive Peers
- Usually Associates with Negative Older Persons

- ☐ Availability/Perceived Access to Drugs
- ☐ Disadvantaged/Disorganized/Impoverished Neighborhood
- ☐ Feeling Unsafe in Neighborhood
- ☐ High Crime Rate in Neighborhood

- ☐ Academic Failure
- ☐ Disruptive in Class/Suspensions
- ☐ Truancy

Date referral was received:

Referring Professional: _____
Print Sign Date