Families Advocating for Voices of Resilience, Inc.
Family Support Crisis Intervention Provider

798 Rays Road #94, Stone Mountain, Georgia 30083
Office Phone: 404-499-0078 | **Cell Phone**: 404-587-8286
Fax: 404-499-0079 | **Email**
ccoates@favorfamilies.hush.com

Referral Date:

Youth Age:

#1: Youth Information

First Name: Last Name: DOB:

Race: Ethnicity: Gender At Birth: ◯ Female ◯ Male Gender Identity: ◯ Female ◯ Male

Language spoken: Language/communication assistance required: ◯ Yes ◯ No
If Yes, Specify:

Street Address:

City: County: State: GA Zip Code:

Parent/Guardian: Relationship to Youth:

Family Phone Number: Other Number:

Email:

Additional Contact Information:

Name	Relationship	Phone Number

Insurance Carrier: Insurance /Medicaid Number (if applicable):

School Attending: School Grade:
Special School Services:

IEP: ◯ Yes ◯ No Mental Health Diagnosis:

List of Medications and Dosage:

Start Date of Medications:

Presenting Challenges/Concerns

☐Self-Harm ☐Threats of Violence ☐Substance Abuse/Type ☐Sexual Offense ☐Fire Setting
☐Runaway ☐Behavioral Problems at School ☐Imminent Risk of Out-of-Home Placement
Describe Challenges/Concerns: (If additional space is needed please continue on last page of document)

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#2: Referral/Agency Details

Please check referral source type:

☐ Parent/Guardian inpatient Hospital Residential Facility (PRTF) Department of Juvenile Justice	☐Private Provider or Pediatrician ☐Juvenile Court ☐DFCS (non-custody only) ☐DFCS Custody (GA Families 360)	☐School System ☐Crisis Stabilization Unit (CSU) ☐ DBHDD Care Provider

Referrer's Name: Relationship to Youth:

Agency:

Agency Phone Number: Email:

Reason for Referral: (If additional space is needed please continue on last page of document)

#3: Other Involved Agencies Who is Currently Involved:

☐Enrolled in School (check if YES)	☐DBHDD Core Provider	☐Family Support Organization
☐Inpatient Hospital	☐Private Provider or Pediatrician	☐Law Enforcement
☐PRTF (Residential Facility)	☐Juvenile Court	☐Crisis Stabilization Unit
☐Child Caring Inst. (Group Home)	☐DFCS (non-custody only)	☐Georgia Cares (CSEC)
☐Dept. of Juvenile Justice	☐DFCS Custody (GA Families 360)	☐Other: _____

#4: Service received in the past: 3 to 6 months

☐Inpatient Hospital	☐DFCS	☐Youth Development Center
☐# of Inpatient Admissions-	☐Juvenile Court	☐Crisis Stabilization Unit
☐Residential Treatment Facility # of PRTF Admissions:	☐Regional Youth Detention Center # of Stays:	☐# of CSU Admissions: ☐Family Support Organization
☐Child Caring Institute (CCI)	☐DJJ	☐Other: MAAC Pact

Current/Pending Legal Challenges (if applicable):(If additional space is needed please continue on last page of document)

#5: Identified Family Concerns:

☐Parenting Difficulties ☐Homelessness ☐Housing Issues ☐Grief Loss and or Separation
☐Parenting Skills ☐Home Management ☐Mental Health Difficulties ☐Removal of Children
☐Substance Abuse ☐Custody/Guardians ☐Legal Issues ☐Domestic Violence
☐Inadequate Family/Community Support ☐ Unemployment ☐Other:

Brief Youth and Family History: (if more space is necessary go to next page)

Peer Support Service Referral Form (continued)

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Family History (continued) (If additional space is needed please continue on last page of document)

Pediatrician Information:

Primary Care Provider name:

Primary care Provider phone number:

Behavioral Health Provider name:

Behavioral Health Provider phone number:

Is Youth under supervision with DJJ or staying in a DJJ facility? ◯ **Yes** ◯ **No**
Youth's # of placement changes in the past year

Agency Name:

Agency Contact Name: Agency Email:

Agency Contact Telephone Number:

Mental Health Diagnosis (Most Prevalent):

Diagnosed by:

Effective Date of Diagnosis:

Clinic/Agency:

Mental Health Diagnosis (Secondary):

Diagnosed by:

Effective Date of Diagnosis:

Clinic/Agency:

Does youth currently take prescribed medications? ◯ **Yes** ◯ **No**

Medication(s):

Peer Support Service Referral Form (continued)

Please complete the following Current Clinical Information based on the diagnosis from Mild to Chronic and where applicable N/A for not applicable.

Diagnosis	Mild	Moderate	Severe	Acute	Chronic	N/A
ANXIETY DISORDERS						
Obsession/Compulsion	☐	☐	☐	☐	☐	☐
Generalized Anxiety	☐	☐	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	☐	☐
Somatic Complaint	☐	☐	☐	☐	☐	☐
PTSD Symptoms	☐	☐	☐	☐	☐	☐
MANIA						
Insomnia	☐	☐	☐	☐	☐	☐
Grandiosity	☐	☐	☐	☐	☐	☐
Pressured Speech	☐	☐	☐	☐	☐	☐
Racing Thoughts/Flight of Ideas	☐	☐	☐	☐	☐	☐
Poor Judgement/Impulsiveness	☐	☐	☐	☐	☐	☐
PSYCHOTIC DISORDERS						
Delusions/Paranoia	☐	☐	☐	☐	☐	☐
Self-Care Issues	☐	☐	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	☐	☐
Disorganized Thought Process	☐	☐	☐	☐	☐	☐
Loose Associations	☐	☐	☐	☐	☐	☐
DEPRESSION						
Impaired Concentration	☐	☐	☐	☐	☐	☐
Impaired Memory	☐	☐	☐	☐	☐	☐
Psychomotor Retardation	☐	☐	☐	☐	☐	☐
Sexual Issues	☐	☐	☐	☐	☐	☐
Appetite Disturbance	☐	☐	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐	☐	☐
Hopelessness/Helplessness	☐	☐	☐	☐	☐	☐

Please complete the following Current Clinical Information based on the diagnosis from Mild to Chronic and where applicable N/A for not applicable.

Diagnosis	Mild	Moderate	Severe	Acute	Chronic	N/A
SUBSTANCE ABUSE						
Loss of Control of Dosage	☐	☐	☐	☐	☐	☐
Amnesic Episodes	☐	☐	☐	☐	☐	☐
Legal Problems	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐
Opiate Abuse	☐	☐	☐	☐	☐	☐
Prescription Medication Abuse	☐	☐	☐	☐	☐	☐
Polysubstance Abuse	☐	☐	☐	☐	☐	☐
PERSONALITY DISORDER						
Oddness / Eccentricities	☐	☐	☐	☐	☐	☐
Oppositional	☐	☐	☐	☐	☐	☐
Recurring Self Injuries	☐	☐	☐	☐	☐	☐
Sense of Entitlement	☐	☐	☐	☐	☐	☐
Passive Aggressive	☐	☐	☐	☐	☐	☐
Dependency	☐	☐	☐	☐	☐	☐

RESPONSE TO CURRENT TREATMENT: Presenting Problems (Include Historical)

☐ Self Harm	☐ Fire Setting	☐ Runaway	☐ Sexual Abuse
☐ Property Destruction	☐ Threats of Violence	☐ Active Substance Use	☐ Sexual Offense

BEHAVIORAL PROBLEMS

Imminent risk of out-of-home placement

Please provide details for any Presenting Problems listed on previous two pages within the last 180 days (6 months).

Youth and Family History: Is the youth able to meet basic needs, fulfill usual role maintaining health and wellness? (if no please explain). ◯ Yes ◯ No

What are the current stressors in the home environment?

Natural Supports Involved?

Type of Service	Location of Service Provided	Admission Date	Discharge Date	Number of Admissions
Inpatient – Hospital				
Residential Treatment Facility				
Child Caring Institute (CTT)				
DJJ				
DFCS				
Juvenile Court				
Regional Youth Detention Center				
Youth Development Center				
Crisis Stabilization Unit				
Other				

DOCUMENTATION RECEIVED	YES	NO	DATE
Parent/Guardian advised of services provided by FAVOR Peer Support and has given consent for this referral to be placed	◯	◯	
Parent has confirm/agreed to support from FAVOR Peer Support	◯	◯	
The following information has been obtain: Diagnosis Verification, Behavioral Health Assessment, CSU/PRTF Discharge documents, Psychological, DR. Appt note, CANS and copy of Insurance Cards.	◯	◯	

Thank you for your referral. Your referral will be reviewed; contact will be made within 24 days.

Additional text for fields with not enough space

Describe Challenges/Concerns:(continued)

Reason for Referral: (continued)

Current/Pending Legal Challenges

Family History (continued)

Click Here To Submit Completed Form